

THE ROLE AND TASK OF THE MEDICAL SOCIAL WORKER

IN A REHABILITATION SETTING

An evaluation of selected patients at the  
Rehabilitation Clinic, Karl Bremer Hospital, Bellville

by

ANITA HANEKOM

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ABSTRACT

In this study the writer assumed that the psycho-social characteristics of physically disabled patients would influence the role and task of the medical social worker at the Rehabilitation Clinic. Therefore an attempt was made to determine the psycho-social characteristics of patients referred to the Rehabilitation Clinic. Furthermore an attempt was made to determine the role and task of the medical social worker in relation to these psycho-social characteristics.

The research method was a descriptive one, using archival data; the latter being social work records of interviews with patients. Prior to the research a literature study was done on various aspects of physical disability and vocational rehabilitation.

A sample group of 45 subjects was compiled by a random sampling technique. Two structured schedules were used to extract data from both the social work file and the Rehabilitation Clinic patient file. The research and processing of the information was done manually.

The findings revealed the following

1. The majority of the physically disabled patients were Coloured males in the age category of 31-50 years.

(ii)

2. These patients had poor educational qualifications and were previously unskilled or semi-skilled labourers.
3. The patients were unemployed and had no income.
4. These patients had a passive lifestyle with no hobbies or little religious involvement. They also habitually abused liquor and/or cannabis.
5. The housing conditions of these patients were inadequate and primitive.
6. The various roles of the medical social worker included those of rehabilitation counsellor, team member, co-ordinator/resource manager and teacher, whereas the tasks included assessment, dissemination of information, referrals, co-ordinating of services and education.

The final conclusion in this study was that the role and task of medical social worker was influenced by both the psycho-social characteristics of referred patients as well as the expectations of the rehabilitation team of the Rehabilitation Clinic.

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TABLE OF CONTENTS

	<u>Page</u>
ABSTRACT .....	(i)
ACKNOWLEDGEMENTS .....	(iii)
INTRODUCTION .....	1
 <u>PART ONE : THEORETICAL ASPECTS OF DISABILITY AND REHABILITATION</u>	
<u>CHAPTER 1 : THE FOUNDATIONS OF REHABILITATION</u> .....	6
1.1 Concept and Principles of Rehabilitation ..	6
1.2 Disability and the Community .....	8
1.3 The Extent of the Problem .....	10
1.4 Definitions used in Disability and Rehabilitation .....	11
1.5 Conclusion .....	18
<u>CHAPTER 2 : THE PSYCHO-SOCIAL ASPECTS OF DISABILITY</u> ..	19
2.1 Introduction .....	19
2.2 Social Aspects .....	20
2.2.1 Environmental Factors .....	20
2.2.2 Housing .....	21
2.2.3 Mobility .....	23
2.2.4 Education .....	25
2.2.5 Finance .....	30
2.2.6 Family Life .....	32
2.2.7 Vocational Aspects .....	38
2.3 Psychological Aspects .....	47
2.3.1 Self-concept, Self-esteem and Body Image .....	48
2.3.2 Disability and the Coping Process ..	54
2.3.3 Disability and Acceptance .....	62
2.4 Conclusion .....	64
<u>CHAPTER 3 : WORKING WITH THE PHYSICALLY DISABLED : THE ROLE AND TASK OF THE MEDICAL SOCIAL WORKER IN A VOCATIONAL REHABILITATION SETTING</u> ...	65
3.1 Introduction .....	65
3.2 The General Contribution of Social Work in a Rehabilitation Setting .....	66
3.3 The Role and Task of a Medical Social Worker in a Vocational Rehabilitation Setting .....	66

3.3.1	The Role of Rehabilitation Counsellor/Case Manager .....	69
3.3.2	The Role of Co-ordinator/Resource Manager .....	71
3.3.3	The Role of Team Member .....	75
3.4	Rehabilitation Counselling .....	77
3.5	Approaches in Rehabilitation Counselling ..	89
3.5.1	Individual Therapy .....	90
3.5.2	Group Therapy .....	91
3.5.3	Family Therapy .....	94
3.6	Conclusion .....	96

## PART TWO : REHABILITATION IN PRACTICE

### CHAPTER 4 : THE REHABILITATION CLINIC AT KARL BREMER HOSPITAL, BELLVILLE, CAPE .....

4.1	Historical Overview of the Rehabilitation Clinic .....	97
4.2	Functioning of the Rehabilitation Clinic ..	99
4.3	Functioning of the Medical Social Worker ..	102
4.4	Conclusion .....	107

### CHAPTER 5 : RESEARCH METHODOLOGY .....

5.1	Objectives of the Study .....	108
5.2	Research Method .....	109
5.3	Premise of the Study .....	109
5.4	Method of Study .....	109
5.4.1	Sample .....	109
5.4.2	Limitations of the Study .....	110
5.5	Research Tools .....	110
5.5.1	Review of the Literature .....	110
5.5.2	Data Collection .....	110
5.6	Schedule Administration .....	113
5.6.1	Testing the Schedules .....	113
5.6.2	Administration of the Schedules ...	113
5.6.3	Limitations of the Schedule Administration .....	113
5.7	Data Analysis .....	114
5.8	Limitations to the Study .....	114
5.9	Conclusion .....	115



<u>CHAPTER 6 : FINDINGS</u> .....	116
6.1 Introduction .....	116
6.2 The Psycho-social Characteristics of Patients referred for Social Work Services .....	116
6.3 Social Work Services rendered at the Rehabilitation Clinic .....	137
6.4 Summary of Findings .....	147
6.5 Conclusion .....	150
<u>CHAPTER 7 : CONCLUSIONS</u> .....	151
7.1 Introduction .....	151
7.2 The Psycho-social Characteristics of Disabled Patients referred to the Rehabilitation Clinic .....	152
7.3 The Role and Task of the Medical Social Worker at the Rehabilitation Clinic .....	154
7.4 Recommendations .....	157
7.4.1 Introduction .....	157
7.4.2 Recommendations : Rehabilitation Clinic .....	158
7.4.3 Recommendations : Medical Social Worker : Rehabilitation Clinic ....	159
7.5 Implications for further Research .....	160
7.6 Evaluation of the Study .....	161

APPENDIX

	<u>Page</u>
ITEM 1 .....	164
ITEM 2 .....	165
ITEM 3 .....	166
ITEM 4 .....	168
ITEM 5 .....	176

LIST OF TABLES

TABLE 1.1 .....	10
TABLE 2.1 .....	58
TABLE 3.1 .....	71
TABLE 3.2 .....	74/75
TABLE 3.3 .....	84/85/86
TABLE 3.4 .....	92
TABLE 6.1 .....	117
TABLE 6.2 .....	118
TABLE 6.3 .....	120
TABLE 6.4 .....	122
TABLE 6.5 .....	123
TABLE 6.6 .....	126
TABLE 6.7 .....	127
TABLE 6.8 .....	129
TABLE 6.9 .....	132
TABLE 6.10 .....	134
TABLE 6.11 .....	135
TABLE 6.12 .....	136

TABLE 6.13 .....	139
TABLE 6.14 .....	141
TABLE 6.15 .....	142
TABLE 6.16 .....	144
BIBLIOGRAPHY .....	178

PART ONE

THEORETICAL ASPECTS OF DISABILITY AND REHABILITATION

## INTRODUCTION

Rehabilitation with physically disabled people is a multi-faceted concept. This includes the facet of physical rehabilitation, which focuses on mobility and independence; social rehabilitation, which deals with the integration of disabled people into society; and psychological rehabilitation which focuses on self-acceptance and psychological adjustment to the disability. Vocational rehabilitation aims at retraining the disabled person to work, despite physical limitations. These facets are not mutually exclusive but are very much interrelated. In this study the emphasis will be on vocational rehabilitation.

Since the earliest times there has been a stigma attached to being disabled an attitude on the part of society that persists to the present day. In the labour market particularly, disabled people have to endure discrimination and negativism, which according to Sutherland (1981:33) may limit

"access to work that is suited to (their) capabilities"

or which may lead to work as being defined as

"suitable' for (them, by taking) more account of (their) supposed incapacabilities."

The above emphasizes that employers often limit their views of an employee's potential as they do not see beyond the handicap itself.

Rusk (1964:289) stated that rehabilitation medicine differs from other types of medicine. He says that vocational assessment of a disabled person

"..... requires the abilities and skills of a complete rehabilitation team ..... to assist the patient in reaching the maximum of his (her) physical, emotional, social and vocational potentials."

From his writings it is obvious that Rusk (1964) feels that vocational rehabilitation (if possible) should be the highest aim of a rehabilitation team. Vocational rehabilitation strives to help disabled persons to achieve economic self-sufficiency as well as offering persons some role in society in which they may be reasonably fulfilled.

The main aim of this dissertation is to describe the role and task of a medical social worker in a vocational rehabilitation setting where the main aim is the evaluation of the disabled person's work potential with a view to referral to appropriate facilities in the community. Thus one could say that the writer is involved in vocational rehabilitation because vocational evaluation is one of the first steps to vocational rehabilitation.

As far as could be ascertained no published theoretical works on this subject are currently available in South Africa. Furthermore the Human Sciences Research Council confirmed that no thesis or post graduate study is currently being done on this subject.

International literature, consulted by the writer revealed that research either focused on the techniques of the rehabilitation counsellors (Scofield 1984), or on the psychological aspects of disability and the implications these have for rehabilitation (Krueger, 1981-1982) or on problems such as unemployment (Brair 1980) and mobility (Crewe and Zola 1983). The role and task of the social worker in a vocational rehabilitation setting for physically disabled people was not addressed explicitly.

In general, literature on rehabilitation and disability tends to specialize on a particular disability. Similarly services to disabled people tend to be specialized. At times this may cause unnecessary duplication and fragmentation of services. Regular perusal of Rehabilitation in South Africa revealed that vocational rehabilitation is also specialized according to the type of disability: for example some protected workshops cater only for a specific disability such as cerebral palsy or epilepsy. A lack of discussion on the role of social work was also revealed. The writer therefore consulted international literature with a view to extracting information that could serve as guidelines in developing countries, such as South Africa. Although basic needs of disabled people are often universal, the services to meet those needs are lacking in developing countries: for example a lack of rehabilitation centres catering for the different phases of rehabilitation.

The dissertation is in two parts. Part One focuses on the theory of rehabilitation, explaining the concept, principles and terminology used in rehabilitation. Attention is also given to psycho-social

spects of disability, such as acceptance of disability, family life, transport and housing. The writer also focuses on the role and task of a medical social worker in a vocational rehabilitation setting, counselling and various techniques used. In Part Two the writer describes the functioning of the Rehabilitation Clinic at Karl Bremer Hospital, Bellville, with a view to evaluating the functioning of the medical social worker in practice. This description is supplemented by a retrospective study of the psycho-social characteristics of a sample group of physically disabled patients referred to the social worker during a specific period, as well as a description of the task and role of the medical social worker in relation to the work she undertook with this sample group. Lastly, the research findings are compared with the theory described in Part One. By this comparison the present social work service at the Rehabilitation Clinic at Karl Bremer Hospital is evaluated in order to make appropriate recommendations which could lead to a more effective social work service.

The writer believes that if a job description of the role and task of the medical social worker is drawn up, it should be done in relation to the psycho-social characteristics of the patients referred. The writer feels that the psycho-social characteristics of referred patients influence the tasks and roles of the medical social worker. For example: impoverished, deprived patients may request greater practical intervention before attention can be given to their emotional problems.



This dissertation is addressing the needs of the physically disabled and the terms disabled, physically disabled, disabled people, disabled persons and patients will be used synonymously.

Lastly, the writer wishes to emphasize that this study is limited to the extent that the rehabilitation setting under consideration deals mainly with vocational evaluation of physically disabled people.

This implies that the role and task of the social worker is inevitably restricted by the main objective of this specific rehabilitation clinic.

## CHAPTER ONE

### THE FOUNDATIONS OF REHABILITATION

#### 1.1 CONCEPT AND PRINCIPLES OF REHABILITATION

The concept of rehabilitation is holistic in nature and represents the third phase of medicine, following the preventive and curative phases.

The World Health organisation (United Nations: "World Programme of Action Concerning Persons", United Nations, 1983:3) defines rehabilitation as a

"..... goal-orientated and time-limited process aimed at enabling an impaired person to reach an optimum mental, physical and/or social functional level, thus providing him or her with the tools to change his or her own life. It can involve measures intended to compensate for a loss of function or a functional limitation (for example by technical aids) and other measures intended to facilitate social adjustment or readjustment."

Rusk (1964:11) lists three objectives of rehabilitation:

- (i) The elimination of a physical disability to the greatest extent possible.
- (ii) The reduction or alleviation of the disability to the greatest extent possible.

- (iii) The retraining of a person with a residual disability, to enable that person to exist within his or her limitations, but to the maximum of his or her capabilities.

Rehabilitation, according to Goldenson et al (1978:8), has four interrelated phases, namely, physical, vocational, social and psychological. Physical rehabilitation would include corrective surgery, the prescribing of medicine and the application of range-of-motion exercises. Vocational rehabilitation generally is an important aspect of rehabilitation because the therapeutic worth of employment is acknowledged, and stigmatization, which handicaps so many disabled patients, is decreased. Vocational rehabilitation would include counselling, testing, occupational and work adjustment training, as well as job placement. Social rehabilitation is used to assist the disabled patient to participate again in community life. This phase of rehabilitation may involve client participation in therapeutic or self-help groups, sex and marriage counselling, clubs and recreational activities. Lastly, the psychological phase of rehabilitation implies the use of personal counselling, psychotherapy, supportive and motivational measures, thus assisting the patient to accept himself and to co-operate with the rehabilitation team in a rehabilitative programme.

Rehabilitation should be based on principles representing the humanitarian philosophies which form the basis of rehabilitation. Wright (1981:266-269) compiled a list of principles which are essential in work with the disabled. Respect and encouragement are important, in order to prevent despair and feelings of devaluation.

Environmental conditions must always be considered, as these could increase or diminish the severity of the handicap. Problems in the social and physical spheres of life need attention as they can cause problems in the patient's adjustment to the disability. The worker assisting the disabled patient should focus on the patient's attributes without being patronizing. Feelings about the self and the disability should be explored and dealt with, because the psychological aspects of a disability are an integral part of the rehabilitation programme. The right of the patient to self-determination should be acknowledged, and his family should be included in the rehabilitation programme where appropriate, because patient and family are an interrelated unit.

In the rehabilitation programme, the team approach is essential. Interdisciplinary and inter-agency collaboration and co-ordination is needed because of the diversity of the patient's needs. Although there are diversities in the needs of the disabled, certain commonalities exist (for example: the stigmatization as a minority group), and in this respect self-help organizations must be utilized to support the rehabilitation programme.

## 1.2 DISABILITY AND THE COMMUNITY

From ancient times, many communities have tended to view disability as a punishment for sin or immoral behaviour. Even in literature, the disabled are viewed in a negative light. As Thurer (1980:12-15) says:

"What becomes obvious from even a cursory examination of literature is that bodily intactness and glowing health are almost exclusive characteristics of the good

and noble, while physical infirmities are reserved for the evil and the malevolent."

The disabled are thus viewed as a minority group, in that their disabilities differentiate them from the able-bodied who tend to deny them complete social acceptance. The severely disabled patient is regarded as being less than human. Sutherland (1981:58) sums it up:

"We are held to be visually repulsive; helpless; pathetic; dependent; too independent plucky, brave and courageous; bitter, with chips on our shoulders; evil (the "twisted mind in a twisted body"), mentally retarded; endowed with mystical powers and much else."

The stigmatization of the disabled is also evident in discriminatory employment. Many disabled patients are able to relate their disappointment and feelings of devaluation at having being refused work or having been assigned tasks unsuitable for them to perform. The present situation in South Africa is such that many disabled people irrespective of the severity of the disability are excluded from obtaining permanent posts, especially in the government sector. There is also no legislation to compel employers to appoint a certain percentage of disabled people to their staff as there is in Britain.

This stigmatization by the community has a serious and negative influence on the disabled. Because they are aware of the community's negativism, disabled people are often suspicious, hostile and anxious. Furthermore, many disabled people may deny the phenomena of stigmatization, by acting as though it does not exist. It is evident that both professional and disabled persons have a responsibility to educate the community so as to modify their attitudes.

In rehabilitation the extent or prevalence of disability in any community is important as this is related to rehabilitation facilities and rehabilitation programmes.

### 1.3 THE EXTENT OF THE PROBLEM

According to the United Nations, 10% of the world's population is disabled. During 1986, The Year of the Disabled Persons in South Africa, it was revealed that 12,7% of the population are disabled. This calculation was based on the 1985 census and implies that 127,13 out of every 1 000 people are disabled (Department of Health and Population Development, 1986 (1987:1:14)).

An analysis of the census data revealed the following prevalences:

TABLE 1:1 DISABLED PEOPLE COMPARED WITH TYPE OF DISABILITY

DISABILITY	NUMBER OF DISABLED PER 1 000 PEOPLE
Hearing-impaired	35,00
Visually-impaired	3,63
Physically Disabled	16,30
Cerebral Palsied	2,50
Epileptic	2,00
Autistic	0,20
Intellectually Handicapped	30,00
Mentally Handicapped	2,50
Speech-impaired	25,00
Chronically Ill	5,00
Genetically Defective	5,00

Source: Department of Health and Population Development,  
Co-ordination Committee, Year of Disabled Persons,  
1986 (1987:1:15)

One can imagine that with the current political unrest, urban terrorism and high incidence of motor vehicle and industrial accidents, this figure may rise much higher, which creates a far more serious need for the development of rehabilitation programmes.

When discussing rehabilitation and disability it is important to use precise terminology to avoid confusion and misunderstanding of the foundations on which rehabilitation is based.

#### 1.4 DEFINITIONS USED IN DISABILITY AND REHABILITATION

Certain terms in rehabilitation need clarification to avoid confusion. The World Health Organisation (WHO) compiled a manual in 1980 which classifies the consequences of disease (or trauma) namely impairment, disability and handicap.

##### 1.4.1 Impairment. According to the WHO (1980:47)

"an impairment is any loss or abnormality of psychological, physiological, or anatomical structure or function."

The impairment may be visible such as a defective limb or the loss of a limb through amputation. But the impairment may also be invisible such as a disease affecting the body, for example renal failure which effects bodily function.

##### 1.4.2 Disability. WHO (1980:143) maintains

"a disability is any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being."

Thus disability is an indication of what an individual is unable to do, for example blindness (unable to see) or

paralysis (loss of mobility due to central nervous system injury).

According to Davies (1982:6-7) disabilities can be categorized in the following way:

1.4.2.1 Congenital - which is subdivided into:

- (i) Hereditary - that is passed on from parent to child.
- (ii) Developmental - defects in the developing foetus, and
- (iii) Those associated with damage to the child during pregnancy or birth.

1.4.2.2 Acquired - These are disabilities which develop later in the life of an individual who was normal at birth. The cause of acquired disabilities are twofold:

- (i) Accidents, for example, motor vehicle accidents which cause paraplegia or quadriplegia.
- (ii) Illness, for example, brain haemorrhages resulting from Cerebral-Vascular Accidents (CVA's).

Davies (1982:7) further maintains that disabilities may be single or multiple, for example, a paraplegic with a head injury. A disability may be static (the condition remains the same all the time) or it could be progressive (the disability worsens with time).



Davies divides progressive disabilities into three categories:

- (i) Steady or intermittent deterioration, until the patient is bedridden or dies, for example, muscular dystrophy.
- (ii) Deterioration which continues until total disability is experienced and the disease has "burnt itself out", for example, rheumatoid arthritis.
- (iii) Deterioration which erupts suddenly and then unexpectedly disappears, leaving no symptoms, for example, in some cases of multiple sclerosis.

For the purpose of this study the use of the term disability will refer mainly to physical disabilities because the Rehabilitation Clinic at Karl Bremer Hospital focuses mainly on physically disabled persons and not on psychiatric disabilities.

Related to the above discussion, it is necessary to mention that there are various degrees of disability ranging from mild to moderate or severe disabilities. It is obvious then that a person's degree of disability will have an affect on his/her rehabilitation, especially vocational rehabilitation. For example it would be easier for a mildly disabled person with a slight tremor to return to his/her previous vocation, than for the severely brain injured person. It is also important to remember that disabled persons may also be socially disabled by low education, poor

housing conditions, lack of transport, support systems and finance.

1.4.3 Handicap. WHO (1980:183) defines a handicap as:

"a disadvantage for a given individual, resulting from an impairment or a disability, that limits or prevents the fulfillment of a role that is normal (depending on age, sex, and social and cultural factors) for that individual."

A handicap can be viewed as the degree of functional limitation, reflecting the consequences for the individual with regards to aspects such as economic factors, environmental factors and social factors.

Although a handicap may be viewed in a negative light, it may well happen that an individual is able to adjust so positively to his/her disability for example paraplegia, that they may well be able to function and work independently despite their disability. In the latter it is accepted that well adjusted disabled persons will have worked through their feelings of anger, bitterness and loss. One must acknowledge that they will be handicapped, but perhaps then due to societal and cultural factors as well as personal feelings of anger, bitterness and self consciousness which affects interpersonal relationships and not by the impairment itself.

Davies (1982:8) mentions other medical terms which are noteworthy. They are explained as follows:

- (i) **Acute** refers to a sudden onset of any disease, or a sudden deterioration in a diseased patient. The main feature of "acute" is that the symptoms are short-lived, serious and quite definite.
- (ii) **Chronic**, in the context of disabilities, means that the condition is constant and long-term. Chronic does not indicate the severity of the condition - it merely indicates the length of time of the condition.
- (iii) **Prognosis** refers to the future outlook of the disability. It is most difficult to assess the prognosis of a disability. In order to be realistic, it is essential that the rehabilitation team's members are in agreement, since only a full understanding of all the facts (together with consensus on the patient's future), will assist them to approximate the prognosis and to face the patient with the truth about his/her disability.

For the purpose of this study other rehabilitation terms need to be mentioned as they are specifically related to rehabilitation.

The terms are:

- 1.4.4 **Medical Rehabilitation.** According to Grabe *et al* (1988:12) this is the process by which an impairment is prevented from becoming a disability. The process of medical rehabilitation

has the purpose of hastening the curative process and minimizing the possibility of permanent disability. Medical rehabilitation could include paramedical services such as speech therapy, physiotherapy, occupational therapy and the prescription of orthopaedic appliances such as orthopaedic boots and orthoses.

- 1.4.5 Vocational rehabilitation. Grabe et al (1988:12) see vocational rehabilitation as part of the rehabilitation process and involves the provision of vocational services such as vocational guidance, vocational training and selective placement that aids a disabled person to obtain secure suitable employment. The importance of vocational rehabilitation is appropriately emphasized in Allen's (1958:75) reference to Galan's statement in the 2nd century AD:

"Employment is nature's best physician and essential to happiness."

- 1.4.6 Vocational evaluation. The main task of the Rehabilitation Clinic at Karl Bremer is that of vocational evaluation (also known as work assessment). A precise definition of this term is therefore of most importance.

The Report of the Working Committee on Training and Employment of Disabled People: Year of Disabled Persons 1986 (1987:24:91) has the following definition:

"Work evaluation is a comprehensive process by means of which the degree of fitness for work of a person is determined."

The writer feels that besides vocational evaluation per se, there is also a need to obtain medical, psychological, social, educational, vocational and cultural data in order to appropriately refer the disabled person for further training or vocational placement.

- 1.4.7 Pre-vocational Training. According to Grabe et al (1988:12) the above implies:

"... a range of occupational activities ... to (re)prepare people for choosing an occupation or training; to (re) acquaint them with different materials, tools, machines, procedures and elementary theoretical knowledge; and to (re)acquaint them with working methods and with the standards expected at work."

From the above the writer gathers that pre-vocational training can be viewed as transitional phase for those disabled persons who are not yet ready for vocational training.

- 1.4.8 Vocational Training. Grabe et al (1988:12) viewed this as

"training to develop specific skills and to gain specific knowledge, which will equip the person for a career."

- 1.4.9 Follow-up. The objectives of the follow-up process as proposed by Grabe et al (1988:12a) is to

"(1) ascertain whether placement in a job, vocational training or retraining services have proved to be satisfactory and to evaluate the effectiveness rehabilitation methods;

and

(2) remove, as far as possible, obstacles which would prevent a disabled person from being satisfactorily resettled after work has been obtained."

Pre-vocational training, vocational training and follow-up services are not at present rendered by the Rehabilitation

Clinic under consideration. To the knowledge of the writer some of these services are rendered by the Association for the Physically Disabled in South Africa.

#### 1.5 CONCLUSION

In the preceding chapter various aspects of disability and rehabilitation such as the concept and principles of rehabilitation and definitions related to disabilities and rehabilitation have been discussed.

In the following chapter the writer will focus on certain psycho-social aspects of disability because these aspects cannot be divided from rehabilitation (including vocational rehabilitation). The latter viewpoint is endorsed by Rusk (1964:23):

"Realistically, however, we must realize that many factors - frequently emotional and social more than physical - prevent the return of some disabled persons to competitive employment."

## CHAPTER TWO

### THE PSYCHO-SOCIAL ASPECTS OF DISABILITY

#### 2.1 INTRODUCTION

It cannot be denied that a physical disability, whether visible (for example: paraplegia) or invisible (for example: epilepsy) has a major impact on an individual. A physical disability can necessitate psycho-social adjustments in an individual's personality, behaviour, interpersonal relationships as well as in the environment. Therefore the psycho-social aspects of a disability are interrelated because a disability may create psychological problems such as depression and despondency because of social factors such as loss of mobility, isolation, increased dependence, discrimination in vocational and social life, financial need and inadequate housing. These factors may limit a person from fulfilling a meaningful role in the community. This may not only be the result of physical limitations caused by the disability that handicap a person's access to necessary services or work possibilities but also because of the restricted view that the "able-bodied" often have of what those with disabilities can or cannot do. Furthermore persons with disabilities may hold back due to different fears or even anger, often based on past negative experiences and so again these "psychological" barriers may impinge on the social aspects of their lives.

Furthermore physical handicaps of any degree may be exacerbated by social deprivation for those who are of the lower socio-economic strata. For example: those disabled persons who have no/or inadequate education and are unskilled, by becoming disabled in adult life may be additionally handicapped by their inability to do sedentary work.

## 2.2 SOCIAL ASPECTS

The social aspects addressed in this study include general environmental factors, housing, mobility, education, finance, family life and vocational aspects.

In addition to social attitudes and prejudices that may limit or handicap the disabled in realizing their potential as discussed in the preceding chapter, the writer will now address difficulties that the disabled experience in their integration into community life.

### 2.2.1 Environmental factors

According to Lifches (in Crewe and Zola, 1983:132) (confirmed by Kliment in Goldenson and Dunham, 1978:115) disabled, ill and poor people are generally forced to exist in a restricted environment caused by inaccessible buildings, lack of money and power to change their personal environment, namely their homes to meet their specific needs. For example: a paraplegic person needs a ramp to enter his/her home or a cerebral palsied person may need a computer to communicate.



In the planning of public buildings such as shops, libraries, stations, sub-economic state-provided housing and even street curbs, the needs of the disabled persons are frequently not taken into account. In her work with disabled persons the writer has observed that many are greatly handicapped by general environmental factors. Many Black and Coloured patients live in poorly developed communities with few facilities, for example: long distances to walk to stations; lack of employment facilities; educational and training facilities; resulting in the disabled person being restricted to his/her dwelling. The available facilities are also planned and built for abled-bodied people and do not accommodate the needs of physically disabled people.

#### 2.2.2 Housing

It is accepted that one's residence should be a place of safety and shelter. Unfortunately many people with disabilities in South Africa may live in dwellings without essential necessities such as electricity, water and inside toilet and bathroom facilities. Adding to the lack of essential necessities, physical disabled persons dependent on wheelchairs, crutches, artificial limbs and canes, may be unable to work simply because they cannot leave their homes because there are steps at the entrance or because they live in the upper stories of blocks of flats where no elevators are available.

Lifchez (in Crewe and Zola, 1983:138) as well as Kliment (in Goldenson and Dunham, 1978:113-114) state that accessibility not only includes the ability to enter the house by means of a ramp or an elevator, but also implies adequate room and door sizes for persons using orthopaedic aids, correct counter-heights of working surfaces for wheelchair-bound people, good lighting for partially-sighted people and special communication devices for deaf people.

At present in South Africa there are no government subsidies to help disabled persons to modify their homes so as to make them more accessible. In comparison to the South African situation, Tate and Lee (in Crewe and Zola, 1983:89-110) mention that countries such as Sweden, Denmark and the Netherlands provide special housing allowances to alter dwellings by building ramps or by the alteration of rooms, so as to be wheelchair accessible.

The above mentioned countries, according to Tate and Lee (in Crewe and Zola, 1983:89-110) focus on the integration or normalization of persons with disabilities in society. This approach implies that people with disabilities should be given conditions of life as close as possible to the normal and services should be provided in accordance with individual needs. The writer feels that such a government policy could reduce the problem of stigmatization, build up disabled persons' self-esteem and help them to experience a coping

life style which encourages them to be as vocationally productive as possible.

### 2.2.3 Mobility

Mobility is closely related to vocational rehabilitation and to the integration of people with disabilities in employment. The writer recognizes that personal mobility by means of orthopaedic appliances such as wheelchairs, crutches and artificial limbs is important to enable disabled persons to utilize public and private transportation.

Without transportation, persons with disabilities (whether severely or mildly disabled) are unable to be mobile enough to participate in community activities such as education, recreation as well as employment outside one's residence.

According to Bowe (in Crewe and Zola, 1983:206) accessible transportation implies that able-bodied people and disabled persons should be able to use the same services and facilities at the same prices.

According to Tate and Lee (in Crewe and Zola, 1983:89-101) special facilities provided by countries such as Sweden, Denmark and the Netherlands include:

- (i) Subsidized, special taxis and vans to transport persons to places of work or study. The vans are

equipped with a lift to transport wheelchair-bound people.

- (ii) People with disabilities pay lower fares on trains.
- (iii) Subway stations are equipped with elevators to enhance accessible mobility for persons using crutches, wheelchairs and other orthopaedic appliances.
- (iv) Portable ramps at trains and busses to ensure accessibility.
- (v) Reservation of at least one carriage per train for wheelchair-bound persons and their carers in the case of severely disabled persons.
- (vi) Subsidies for disabled persons who wish to purchase their own, modified hand control motorcars.

Bowe (in Crewe and Zola, 1983:206-209) mentions a noteworthy service, namely dial-a-ride service which implies a door-to-door service by taxis for elderly and physically disabled persons. For persons who do not have access to telephones, churches and community organizations such as the Lions, may provide a back-up service by making regular contact.

Similar services in South Africa, as mentioned above, should also be advocated for. Possible services could be:

- (i) Special portable ramps for trains and public busses.
- (ii) The reservation of specific train carriages of some

trains for wheelchair-bound persons.

- (iii) The planning and erection or alteration of stations with ramps and/or elevators.
- (iv) Dial-a-ride service for people (with access to telephones).
- (v) For those without telephones, churches or community organizations may provide a transport service by making regular contact on a daily basis.

Naturally the specific vans and taxis for disabled persons should be altered and equipped according to the specialized needs. For example: provision is needed for those who are wheelchair-bound.

Since the above mentioned services are expensive, government funding, public support and the involvement of people with disabilities seems necessary to initiate the required services.

Transportation, meeting the needs of persons with disabilities would make it much easier for involvement in outside employment. Furthermore accessible transportation could encourage and motivate disabled persons to live a meaningful and purposeful life.

#### 2.2.4 Education

In order to be labour-productive ("arbeidsproduktief"),

education is of great importance.

As mentioned above, there is a lack of educational, training and employment facilities. This may contribute to psychological problems such as depression, unresolved anger and apathy which in turn may demotivate persons from seeking rehabilitation for employment. Even if medically and physically rehabilitated, people may experience a succumbing attitude and a low self-esteem due to low education which may inhibit their obtaining employment. For this reason it would seem beneficial that training facilities should differentiate between those who are skilled, unskilled or have to learn new skills.

At present the following vocational rehabilitation facilities operate in the Cape Peninsula:

- (i) The Occupational Therapy Departments at both Tygerberg Hospital and Groote Schuur Hospital offer vocational evaluation services. These services evaluate disabled persons' work potential, as discussed in Chapter One. Once this has been evaluated, the occupational therapist is able to recommend the disabled person to existing, suitable facilities.
- (ii) At Tygerberg Hospital the vocational evaluation area of the Occupational Therapy Department is closely related to the Rehabilitation Clinic at Karl Bremer

Hospital. This Clinic is a co-ordinating, multi-diagnostic clinic. This implies that all the various medical departments in Tygerberg Hospital refer people with disabilities via the Rehabilitation Clinic to the work evaluation area. This method ensures a co-ordinated service, based on the team approach. The latter furthermore ensures that disabled persons are referred to appropriate facilities and that the appropriate services are rendered.

- (iii) Certain pre-vocational and vocational training facilities for people with disabilities who are fit for the open labour market, include:
  - o The Western Cape Training Centre which falls under the auspices of the Department of Manpower. Although this Centre mostly offer training services for the unemployed, very mildly disabled persons may also benefit from training courses for domestic workers and bricklayers.
  - o The Rehabilitation Centre at Athlone which falls under the auspices of the Association for the Physically Disabled. This Centre has a comprehensive rehabilitation programme which is geared for both moderate to mildly disabled persons who are able to obtain and retain employment in the open labour market. The

rehabilitation programme is noteworthy, because it attends not only to pre-vocational and vocational training of work skills, but also to the interpersonal, environmental and intrapsychic difficulties. This programme is based on the psycho-social approach which acknowledges that psycho-social factors are interrelated.

Unfortunately this Centre is only available for Coloured people and no similar facilities are available for Black or White people. Hopefully future development of the Rehabilitation Centre could provide services for all racial groups.

- o The writer acknowledges that a fairly big group of disabled people can be retrained at institutions for the able-bodied. Example of such institutions are universities and technicons. It is noteworthy to mention that the University of Cape Town has a Disability Unit that works in the interest of disabled students.

At present a lack of formal pre-vocational and vocational services (as discussed in the previous chapter) exist for people who are unfit for the open labour market. Those who



are fit for sheltered and protective employment are currently receiving limited pre-vocational training at Occupational Therapy Departments at certain provincial hospitals such as Tygerberg Hospital and Groote Schuur Hospital.

The writer recognizes the importance of the implementation of the phases of pre-vocational and vocational training (as discussed in Chapter One) for disabled persons fit for sheltered, protective employment and home-industries.

The Working Committee : Training and Employment of Disabled People : Year of Disabled Persons, 1986 (1987:24:53-68) recommended the establishment of vocational training and employment facilities at a Vocational Training Centre. The above mentioned Working Committee explicitly outline their recommendations and also advocates for a vocational placement unit which will have the aim of placing people with disabilities in suitable employment.

The phases of pre-vocational and vocational training are important for successful employment because attention is given to the disabled person's work personality and work competence. The writer feels that if these aspects are addressed, it will enhance a positive, confident, coping lifestyle, which in effect may lead to successful and rewarding employment.

#### 2.2.5 Finance

Finance, disability and employment are interrelated. Being disabled as an adult has financial implications such as loss of income, cost of ongoing future medical care as well as obtaining and retaining secure employment. Topliss (1975:63) appropriately states:

"that disabled people tended to be worse off financially in that they are limited to the less prestigious and less well paid jobs."

In South Africa (which is not a welfare state, in comparison with a country such as Britain) disability grants are issued only to disabled people who are unfit for the open labour market or sheltered employment. Therefore it can be accepted that people with mild disabilities, having low education and few working skills will struggle to obtain employment and will suffer severe financial problems.

Some people who sustained disabilities in motor vehicle accidents are unaware of that they are in terms of the Motor Vehicle Accidents Act (Act 84) of 1986 entitled to third party claims and therefore also suffer financial difficulties. Furthermore, third party claims take time to settle which means that the claimants with physical disabilities may also suffer financially. Even those who have employment may incur financial loss due to the expense of hospitalization, medical treatment and orthopaedic appliances.

To cope with the financial difficulties of the lower socio-economic strata, it may be necessary for persons with disabilities, their families, professionals, the community and the State to join forces to support people who have no financial aid.

Government legislation could help to decrease the financial burden of disabled persons. Proposed legislation could include:

- (i) Tax deductible company and private donations to organizations financing programmes for disabled persons.
- (ii) Tax rebates for medical expenses and costs of medical and orthopaedic appliances such as wheelchairs, crutches and oxygen for those suffering from respiratory problems.
- (iii) Obliging companies to employ a percentage of disabled persons as is done in the United States of America (Goldenson and Dunham, 1978:83) and in the United Kingdom (Breachin et al, 1981:114).
- (iv) Government loans or grants to people with mild disabilities who are unable to obtain suitable employment and are waiting for employment at sheltered employment factories.
- (v) The number of sheltered employment factories and protected workshops could be increased. For example:

in the whole of South Africa only 13 sheltered employment factories are in operation; two of them operate in Cape Town. As far as the writer could ascertain 18 protected workshops for people with various mental and physical disabilities and for all racial groups exist in the Cape Peninsula (Year of Disabled Persons, 1986, Department of National Health and Population, 1987:36).

- (vi) Government grants or loans to modify homes of disabled persons to accommodate their specific disabilities.

The above examples of possible legislation can give a disabled person a sense of security and protect him/her from being overwhelmed by financial problems.

#### 2.2.6 Family life

It is well documented in the literature that the disability of a family member has as enormous impact on family life. (Power and Dell Orto, 1980:161). The family's response to the disabled member will partly determine his/her motivation and preserverance to be rehabilitated both medically and vocationally. Power and Dell Orto (1980:145-147) agree that the following factors help families to manage their disabled member in a positive way:

- (i) Open, clear communication in the family.
- (ii) Emotional strengths such as support from the extended

family.

- (iii) Availability and use of community resources.
- (iv) Decreasing and/or adjusting of personal ambitions of the other family members.
- (v) Role reversals in the family. (For example: a husband of a disabled wife may have to take on some of the household tasks such as cooking or doing the laundry).

This, however, does not necessarily eliminate emotional problems within the family (Brechin *et al*, 1981:55). Bray (in Power and Dell Orto, 1980:161f) states that the family usually experience similar emotions, concerns and conflicts as the patient himself. He therefore conceptualized a framework of family reactions in three stages namely the anxiety stage, the acceptance stage and the assimilation stage. Professionals should be alerted to these stages so as to prevent unnecessary difficulties and render supportive services where necessary.

Bray (Power and Dell Orto, 1980:162) described the anxiety stage as including the following emotions: initial fear for the disabled family member's life as well as a denial of a permanent handicap. This denial is expressed in various forms, for example: anger and refusal to deal with staff members who confronted the family with the reality of a permanent disability of their family member. Another form of

denial is a turn to religious beliefs as a hope for improvement or healing. Depression is also another form of anger, (the writer realizes that anger can also be related to the loss suffered) as Bray (Power and Dell Orto, 1980:162) says:

"The foundation of their (the family's) depression is impotent anger."

Bray (Power and Dell Orto, 1980:163) maintains that the family's emotions is in a state of flux during the acceptance stage. He furthermore states that during this phase the rehabilitation team has a responsibility to help the family work through their feelings of loss and partial acceptance. As a family is able to move to the final aspect of acceptance, members are able to express hidden, guilt ridden feelings and even anger and hostility towards the disabled family member. (Confirmed by Charlis Dunham in Goldenson and Dunham, 1978:22-23).

If the above feelings are repressed, they may be expressed in devious ways such as acting-out behaviour, overprotection or rejection of the disabled family member.

The last stage of assimilation according to Bray (in Power and Dell Orto, 1980:16) occurs over a period of years. The total reintegration of a disabled family member is retarded because the disabled person is frequently absent from the family due to hospitalization, treatment, evaluation or

training. Bray (in Power and Dell Orto, 1980:163) says that extended absences of a disabled family member often results in:

"emotional insulation and isolation similar to reactions associated with death."

The above statement implies that the family withdraws from society and their support system. (Confirmed by Charlis Dunham in Goldenson and Dunham, 1978:22).

In order to resolve problems incurred by frequent absences, follow-up work (including constant emotional support, ongoing meaningful and realistic information about the disabled family member's condition) is necessary.

If these three stages, namely that of anxiety, acceptance and assimilation are resolved through a family education programme or family therapy (Bray in Power and Dell Orto, 1980:162, confirmed by Goldenson and Dunham, 1978:21), the family is helped to accept their disabled family member back into their family life in a positive and healthy way. If the above mentioned stages are unresolved, there is a risk that the disabled person is either alienated, rejected or overprotected by his/her family, instead of participating in his/her family life, making his/her own decisions and resuming his/her role in the family. Both reactions of alienation and overprotection are negative. Alienation robs the patient from moral and emotional support as well as

motivation for rehabilitation. According to Davies, (1982:15-16) overprotection may discourage independence, causing regression or depression which may lead to a person succumbing to instead of coping with his/her disability. By overprotection families encourage disabled members to adopt a permanent sick role, which leaves no room for medical, social and vocational rehabilitation. Overprotection can discourage the disabled member not to take up his/her previous role because of secondary gain (that is: obtaining attention or "using" his/her disability to obtain emotional or materialistic gains). Secondary gain can contribute to the disabled person's reluctance and or inability to be fully rehabilitated.

Marital relationships are also affected if a spouse sustains a disability such as a stroke, paraplegia, quadriplegia or a severe amputation of several limbs. A positive, warm, accepting marital relationship can be a motivating factor in the rehabilitation process of a disabled spouse. Although certain traditional roles are ascribed to husbands and wives (for example the husband being the breadwinner), Power and Dell Orto (1980:38) report that there is general agreement that the greater the flexibility of roles and even permanent role reversals, the higher the possibility of marital satisfaction. Most important is the fact that role expectations need to be defined clearly and appropriately to avoid unnecessary misunderstanding.



Sex is an integral part of a marital relationship and the physical expression of caring and tenderness can reinforce the disabled spouse's feelings of being accepted and loved. With severe and even mild neurological disabilities such as hemiplegia (that is paralysis affecting one side of the body), paraplegia (that is paralysis of the lower limbs) and hemiparethis (that is a slight or partial paralysis of the body) the marital couple concerned may need sexual counselling to ensure a fulfilling sexual relationship. According to Hartman et al (1983:370-374) sexual counselling should focus on the following:

- (i) New family roles and responsibilities for both marriage partners.
- (ii) The sexual relationship itself.
- (iii) Sexual activity which includes learning new responses related to the disabled spouse's needs, explicit communication expressing the desire for new and different sexual activities, the discovering of new erogenous zones, acceptance of changed body images, exploration of different sexual positions, the increase of erotic stimulation and where necessary the use of sexual aids as well as planning when and where to engage in sexual activity.

Edwards (in Goldenson and Dunham, 1978:29) maintains that

disabled people also have social-sexual needs. Davies (1982:71) adds that persons with disabilities are often seen as asexual. This can result in problematic intimate relationships for the unmarried. Disabled persons are therefore sometimes deprived of an intimate or sexual relationship that could foster their feelings of dignity, self-worth, acceptance and identity. Such feelings encourage the disabled in their endeavours to seek and maintain employment in that they present themselves more positively to prospective employers. The writer agrees with Davies (1982) and Hamilton (in Nichols, 1980:286) that the need of physical disabled people for an intimate relationship and an intimate, special friend/partner should not be negated.

#### 2.2.7 Vocational Aspects

Boswell and Wingrove (1974:29-30) maintain that disabled people, in common with non-disabled people, have an intrinsic need to have a satisfying vocation, but due to societal prejudices, many disabled persons are forced to accept low status, unattractive jobs with low salaries.

Employment is associated with security, identity, independence, self-esteem, competency, food and shelter. Therefore the unemployed disabled person may experience grief, not only for his/her physical losses, but also for the losses of identity, autonomy and self-esteem. Rusk (1964) and Brechin et al (1981:116), feel that work has a

meaningful role in establishing a disabled person's self-worth and self-respect. Rusk (1964:291) appropriately says:

"In some instances work appears a major need for these individuals if they are to feel that it is worthwhile to exist or 'to go on'."

Vocational rehabilitation therefore is an important goal in any rehabilitation programme. The Working Committee : Training and Employment of Disabled People, Co-ordination Committee : Year of Disabled Persons, 1986 (1987:24:26) sees vocational rehabilitation as follows:

"Vocational rehabilitation and training are therefore geared to affording the disabled person the opportunity to develop his[her] remaining capabilities to the optimum, so that he[she] may obtain a suitable job or qualify for a suitable occupation, and to promoting the integration or re-integration of the disabled person into society."

Rubin and Roessler (1978:12) feel that the initial stage of the vocational rehabilitation process is that of evaluation. They (1978:124) regard the goal of the evaluation phase as

"..... directed at determining current client functioning and potential client functioning for purposes of predicting potential future vocational functional levels".

Vocational evaluation is a multi-faceted process. (Andrew in Parker and Hansen, 1981:205f). Rubin and Roessler, 1978:123) regard the intake interview performed by the rehabilitation counsellor (who can be a qualified social worker) as the first step. (The intake interview will be discussed in Chapter Three which focuses on the role and task of the

medical social worker.) The second phase in vocational evaluation, is the medical examination which is often supplemented with specialist examinations and/or psychological evaluation. The medical examination determines the presence and the extent of the physical disability as well as the current physical functioning. Psychological evaluation focuses on the disabled person's psychological adjustment; aptitude for new skill acquisition, ability to sustain motivation for the duration of a training programme and the identification of appropriate work environments. (Rubin and Roessler, 1978:143). These authors add that psychometric tests are useful in helping the disabled person to identify realistic goals.

Rubin and Roessler (1978:146) view the process of vocational evaluation as:

"Allowing for the observation of client performance on actual or simulated work tasks in real or simulated work environments. Work evaluation is an experiential evaluation procedure that utilizes reality based techniques and operations."

The Working Committee : Training and Employment of Disabled People, Co-ordination Committee : Year of Disabled Persons, 1986 (1987:24:5f) endorse Rubin and Roessler's findings and recommendations that vocational evaluation measures and collates data with regard to disabled persons' abilities and potential to be employed. Vocational evaluation includes assessment and observation of work habits, skills, abilities

and aptitudes. The techniques used by occupational therapists in vocational evaluation (Working Committee : Training and Employment of Disabled People : Year of Disabled Persons, 1986 (1987:24:58) endorsed by Rubin and Roessler (1978) and Andrew (in Parker and Hansen (1981) are:

- (i) Formal standardized tests conducted by training officers/psychologists.
- (ii) Job-related activities carried out by the disabled person.
- (iii) Job-simulation where elements of industrial work are simulated and carried out by the disabled person.
- (iv) Job samples (that is samples obtained from industry) are carried out by people with disabilities at the evaluation centre.
- (v) Trial employment (that is the person with a disability is placed in a work situation for a trial period).

To summarize: The above techniques are used by qualified occupational therapists to assess a disabled person's ability and potential to be employed.

Rubin and Roessler (1978:147) feel that other factors also need to be observed and assessed. These include:

- (i) A person's interrelationships with colleagues and superiors.

- (ii) Independence or level of independence.
- (iii) Management of criticism.
- (iv) Attention span.
- (v) Retention of instruction.
- (vi) Physical and emotional stamina.
- (vii) Necessity of encouragement.
- (viii) Need to supervision.

Rubin and Roessler furthermore state that the vocational rehabilitation process includes a planning, treatment and a termination phase.

The planning phase, (Rubin and Roessler 1978:163) is regarded as a vocational analysis of the disabled person's work potential. They (1978:193) furthermore recommend the involvement of the disabled person so as to ensure a realistic and pragmatic rehabilitation plan.

The treatment phase (Rubin and Roessler, 1978:185) deals with a range of services, including medical restoration, work adjustment (that is: personal-social adjustment) and vocational training.

The termination phase (Rubin and Roessler, 1978:207) focuses on job placement which includes job-seeking skills, training programmes, selective placement, the rehabilitation counsellor's attitudes towards placement activities and post-employment services.

People with disabilities may experience a lack of confidence to

engage in employment. This lack of confidence has a variety of causes such as societal barriers (for example: inaccessibility to buildings and lack of training facilities). For the realization of vocational rehabilitation Hershenson (1981:91-97) maintains that a physically disabled person needs development in three areas:

- (i) Work personality; that is the disabled person's self-concept of a worker and personal motivation for work.
- (ii) Work competence; which includes work habits, physical and mental skills applicable to jobs and work-related interpersonal skills.
- (iii) Appropriate, clearly defined work goals.

The writer feels that physically disabled people can experience a development in the previous mentioned areas. For example: a few patients known to the writer, who suffered from a low self-esteem and who were cautious about employment, reported a motivation to work as they gained confidence and competence in their ability to work.

Hershenson (1981:94) has formulated a model to develop these areas in order to be employed successfully. His model consists of the following three intervention phases:

- (i) The restoration (also known as replacement) as far as competence is concerned. This will enhance a disabled

person's self-confidence if he/she is able to realize that they are able to work.

- (ii) Remotivation of the disabled person to work and his/her own role as worker to deal with the impact of the disability on the person's work personality. In the remotivation phase the social worker should help the person with a disability to come to terms with his/her loss and the feeling of anger experienced.
- (iii) Restructuring career goals in terms of the effect of the disability on work goals. The writer feels that if a person has realistic career goals, these goals will also enhance motivation and feelings of competence, which in turn enhances a person's self-worth and self-esteem.

Having performed the evaluation phase, the occupational therapist in consultation with other team members (medical doctors, social workers, physiotherapists and speech therapists) is able to plan vocational objectives in relation to the specific person's needs.

Although Rubin and Roessler (1978:123) propose a planning phase, a treatment phase and a termination phase, the essence of these phases corresponds with the vocational rehabilitation model proposed by Grabe et al, 1988:12-12a namely the vocational pre-training and training phase as well as the follow-up phase. Therefore, although different



writers have different terms for the phases in the vocational rehabilitation process, there seems to be much similarity in the different approaches.

Vocational evaluation is not only the key to the other phases in the vocational rehabilitation process, but also to various employment opportunities. According to the Working Committee: Training and Employment of Disabled People, Co-ordination Committee : Year of Disabled Persons, 1986 (1987:24:78-85) the following employment opportunities exist in South Africa:

- (i) **The open labour market.** This exists in both the private and the public sectors of the economy and the disabled person has to be 100% productive as well as capable of competing with non-disabled people.
- (ii) **Sheltered employment.** In South Africa, sheltered employment is reserved for the physically and mentally disabled people who are at least 50% productive, in comparison with a normal worker. These sheltered work schemes are currently subsidized by the Government. The writer experienced that these factories expect 80% - 100% productivity at present from their workers.
- (iii) **The Protective Labour Market.** These workshops are reserved for disabled people who are 50% or less productive. Task content is simple and repetitive of

nature and the degree of stress and responsibility is low. To the writer's knowledge these workshops do not operate with a profit motive and disabled people are eligible for disability grants when they enter such workshops.

- (iv) **Home Industries.** These schemes assist the housebound physically disabled person who exists on a disability grant to manufacture and sell articles in order to improve his/her financial position. These physically disabled persons are supported by family, friends, or private welfare organizations. The activities undertaken are usually needlework, weaving, simple woodwork and shoe repairing.

The previous mentioned Working Committee lists several problems with regard to job opportunities in the open labour market, sheltered employment, protective employment and home industries (Co-ordination Committee : Year of Disabled People 1986 (1987:24:19-25). A few general problems are noteworthy.

- (i) Discrimination in respect of work opportunities and promotions.
- (ii) Employers are often ignorant or prejudiced.
- (iii) Preparation, evaluation, training and referral of disabled people for job placement are inadequate.

- (iv) Training and evaluation programmes of work skills are inadequate.
- (v) Evaluation and in-service placement facilities are inadequate.
- (vi) A lack of co-ordination exists with regard to policy between government departments and welfare organizations.
- (vii) Inadequate rehabilitation facilities exist.
- (viii) A lack of expertise (occupational therapists, psychologists and social workers) with regard to the evaluation and training of the disabled, with a view to placement and follow-up.

In conclusion the writer feels that a major source of manpower is virtually unutilized. Despite the economic implications, this situation has psychological implications for the disabled person, whether severely, moderately or mildly disabled. Section 2.3 proposes to focus on psychological aspects of a physical disability.

### 2.3 PSYCHOLOGICAL ASPECTS

To understand the physically disabled person the "psychology of disability" needs to be examined because emotional and mental factors can determine the success or failure of the rehabilitation effort. Erikson (in Shaw, n.d.:16) sees the impact of a disability as a breakdown (or traumatic event) in the life of a person. In this

respect a sudden injury and/or disability is a major crisis for any individual and this, after the initial state of shock, may lead to feelings of worthlessness and disillusionment. These feelings may negatively affect self-concept, self-esteem and body image. It is therefore important that those working with the disabled, especially if one is ultimately to help motivate the disabled in attempts to secure suitable work, address the following:

1. self-concept, self-esteem and body image; 2. disability and the coping process and 3. disability and acceptance.

#### 2.3.1 Self-concept, self-esteem and body-image

Self-concept, self-esteem and body image are important factors when resolving the impact of a disability. In the acute phase the social worker may use crisis intervention in helping the person to overcome the impact of a disability. In the long term, full-time employment and involvement in community activities (for example in self-help groups, advocating for special services and legislation, educating society on issues on disability) can counteract negative feelings. Wright (1983:156) maintains that a disabled person with a negative self-concept, self-esteem and body image will tend to experience feelings of inferiority which eventually will effect vocational rehabilitation and eventual employment negatively.

#### Self-concept (also referred to as self-image)

This is the abstract idea (or "picture") one has of oneself

(Brown, 1977:4). One's self-concept influences the way in which one perceives other people's intentions, one's choice of friends and one's goals in life (Wright, 1983:217).

Should a person sustain an impairment which results in a severe/moderate disability, a person's self-concept requires modification in order for that person to experience stability and consistency of the self-concept in the future.

Modification of the self-concept implies that new facts, values and attitudes with regard to the self need to be integrated with the old ones. This integration is a fitting-in process, to link old and new facts, values and attitudes to a Gestalt.

According to Wright (1983:217-220), confirmed by Cook (in Parker and Hansen, 1981:149), a person's self-concept can be detrimentally affected by a disability, but one's perception does not necessarily mirror the views or values of other people. Through the use of defence mechanisms, some individuals tend to protect their self-concept and, in effect, their self-esteem, which is also influenced by their disability.

### Self-esteem

According to Wright (1983:223) self-esteem refers to the evaluation which one has of oneself. A low, negative self-esteem naturally will handicap a physically disabled person to obtain employment, because of the feelings of shame

and self-pity.

There is general agreement in the literature (Brown, 1977:83-89, Wright, 1983:171-172) that the influence of the self-esteem relies on the status value which an attribute (for example: sight/legs/hearing) has, as well as on the connection between the attribute and the self-concept. For example, should a woman value her breasts, regarding them as the core of her femininity and sexuality, it is natural to anticipate that she will regard a mastectomy as a severe blow to her self-esteem.

According to Wright (1983:116-156) disabled people have adopted various strategies to improve their self-esteem. These strategies are:

(i) "As-If" Behaviour

Through the use of "As-If" behaviour, the disabled person attempts to conceal the disability by denying, forgetting or hiding the disability. The "As-If" behaviour causes a constant need to prevent a slip up and this places strain on the disabled person and results in strained emotional relationships. The disabled person is forced to keep a psychological distance from others and is therefore deprived from close, intimate relationships. An example of "As-If" behaviour (mentioned by Wright, 198:120) is pretending

to be a daydreamer or faking absent-mindedness, boredom and indifference.

(ii) **Idolizing Normal Standards**

Although professionals are in favour of the principle of normalization, there is a definite need for caution in how normality is viewed as being the only appropriate way in which to experience acceptance in that society. In idolizing normality, disabled people will have to contend with feelings of inferiority and imperfection, because any behaviour other than normal standard behaviour will be regarded as devalued behaviour. For example, the use of crutches would, in this context, be viewed as inferior behaviour.

(iii) **Compensation as an Indemnity**

Although compensation can be positive, there is also a negative side to it. Wright (1983:14) uses Maslow and Mittleman's description to explain the destructive implication of compensation, namely,

"..... the individual's attempt to make up for an undesirable trait and the consequent discomfort by emphasizing or exaggerating a desirable trait."

The use of negative compensation reflects the disabled person's shame and inferiority. Although success can be achieved by this method, success does not guarantee the person's acceptance of, and adjustment to, the disability.

An example could be achieving academic prowess as a way to compensate for a physical disability. This kind of behaviour can be futile, if the person was unable to attain personal satisfaction because he/she continue to experience persistent feelings of inferiority (Wright, 198:149).

Compensatory striving for successes can therefore cause problems in employment and social situations because these strategies may cause the disabled person to harbour either unrealistic expectations of his/her abilities and/or alienate him/her from colleagues.

### Body Image

Wright (1983:217) regards body image as

"That aspect of the self-concept which pertains to attributes, experiences and functions involving the body ..."

Feelings and attitudes affect one's body image throughout one's life, and when a trauma or accident causes a severe or moderate disability one's body image is impaired and can therefore create a threat and disturbance to one's integrity (Brown, 1977:79).

Brown (1977:80) maintains that the following factors influence a disabled person's reaction to a changed body structure:



- (i) The functional significance of the body part involved. For example if an athlete becomes a paraplegic, one can anticipate that his loss of mobility will be more significant than for the person who is not actively involved in sport.
- (ii) The importance of physical appearance. Society values physical attractiveness and perfection highly and this viewpoint may lead to a distorted body image if one becomes disabled.
- (iii) The visibility of the body part involved. A visible disability, according to Brown (1977:85) implies a greater trauma for the disabled person because he/she has to come to terms not only with personal feelings, but also with the feelings of society.
- (iv) The feasibility and availability of rehabilitation. In certain cases rehabilitation is not feasible, for example a person undergoing a laryngectomy. Brown (1977:87) maintains that training in esophageal speech is not that successful, so a person undergoing a laryngectomy may not attain the same level of rehabilitation as a patient who had suffered a stroke. In the latter example, rehabilitation programmes can effectively minimize permanent distortions of body image.

- (v) The degree of change and rate at which the change of body structure occurred. Progressive change in body structure allows time for adjustment and adaptation. However, an unanticipated illness or traumatic event, causing a change in body structure, may create difficulty in adjustment to a changed body structure.

In discussing the concepts of self-concept, self-esteem and body image it is important that those working with the disabled keep these in mind as they help the disabled modify and adapt in order to participate more fully in society. This is especially so in the realm of vocational rehabilitation as the person ventures first and learns to project themselves more positively and not hold back because of negative attitudes.

### 2.3.2 Disability and the Coping Process

#### 2.3.2.1 Emotional reactions

Theoreticians such as Rusk (1964), Nichols (1980) and Tucker (1980) in the field of physical disability and rehabilitation are in agreement that emotional reactions to a disability proceed in stages. These stages can be compared with Kübler-Ross's conceptualization of the mourning process, (Hughes, 1980:251-259). Kübler-Ross stated that during the process of mourning, terminally ill patients move through the following stages: shock, denial, anger, bargaining, depression and finally, after resolution of the previous stages, acceptance.

Tucker (1980:116) views the emotional reaction to a spinal cord injury and other similar traumatic injuries such as an amputation or stroke as a cycle characterized by

"severe depression, anger, confusion, withdrawal and then noticeable acceptance leading to a gradual re-involvement in life."

Depression, mourning and grief are common emotional reactions which the physically disabled understandably experience, because they are related to multiple and simultaneous losses such as independence, mobility control, loss of pleasant sensations (for example in strokes) and in complete paraplegia and quadriplegia the loss of virility. Losses on a social level are also experienced, such as the loss of a job, love relationships ending, and social standing being affected. Tucker, referring to Gunther (1971) and McDaniel (1976), maintains that the grief process is a necessary one if a rehabilitation programme is to succeed.

Certain patients grieve so deeply about their disability that they become despondent and rehabilitation becomes virtually impossible. In order to identify why certain people are able to adjust to their disability more readily than others, it is necessary to examine the coping-versus-succumbing framework.

#### 2.3.2.2 The Coping-Versus-Succumbing Framework

According to Wright (1983:194) a coping attitude implies that persons with disabilities have an active role in life, in the community and will not allow themselves to be devastated by

difficulties such as architectural barriers, discriminatory practices, lack of employment opportunities, inadequate housing, transportation, education facilities and family problems. Furthermore the coping attitude focuses on the intrinsic or asset value of the disabled person and not on the losses he/she has experienced.

The succumbing attitude on the other hand, focuses on the negative aspects of disability and sees the only solution to a disability as prevention and cure.

In order to develop a coping attitude it is necessary for a disabled person to grieve and come to terms with his/her physical and social losses as discussed above. In helping disabled persons to work through these losses, the social worker has a supportive role as rehabilitation counsellor using various psychotherapeutic approaches which will be discussed in Chapter Three. The writer holds the opinion that a coping attitude is imperative for successful rehabilitation as well as for obtaining and retraining of employment.

To understand the coping and succumbing ways of managing a disability, the writer includes Wright's (1983:195) outline of the coping - succumbing framework. (See table 2:1). The writer feels that professionals should integrate this coping framework when working with people with disabilities. In using the coping framework professionals and disabled persons

are able to manage practical problems in employment, housing, transportation as well as emotional problems such as a low, negative self-esteem, self-concept, distorted body-image, and emotional reactions such as anger, bitterness, shame and depression. It should be remembered that with regard to coping, feelings fluctuate as the disabled person encounter new crises. Furthermore one can cope in some areas of life and not in others. In fact, this applies to all persons, both the able-bodied and disabled.

TABLE 2.1: CHARACTERISTICS OF THE COPING-SUCCUMMING FRAMEWORK

COPING	SUCCUMMING
1. The emphasis is on what the person can do.	1. The emphasis is on what the person cannot do.
2. Areas of life in which the person can participate are seen as worthwhile.	2. Little weight is given to the areas of life in which the person can participate.
3. The person is perceived as playing an active role in molding his or her life constructively.	3. The person is seen as passive, as a victim of misfortune.
4. The accomplishments of the person are appreciated in terms of their benefits to the person and others (asset evaluation), and not devaluated because they fall short of some irrelevant standard.	4. The person's accomplishments are minimized by highlighting their shortcomings (comparative-status evaluation, usually measured in terms of "normal" standards).
5. The negative aspects of the person's life, such as the pain that is suffered or difficulties that exist, are felt to be manageable. They are limited because satisfactory aspects of the person's life are recognized.	5. The negative aspects of the person's life, such as the pain that is suffered or difficulties that exist, are kept in the forefront of attention. They are emphasized and exaggerated and even seen to usurp all of life (spread).
6. Managing difficulties means reducing limitations through changes in the social and physical environment as well as in the person. Examples are: (a) eliminating barriers (b) environmental accommodations (c) medical procedures (d) prostheses and other assistive devices (e) learning new skills	6. Prevention and cure are the only valid solutions to the problem of disability.
7. Managing difficulties also means living on satisfactory terms with one's limitations (although the disability may be regarded as a nuisance and sometimes a burden). This involves important value changes.	7. The only way to live with the disability is to resign oneself or to act as if the disability does not exist.
8. The fact that individuals with disabilities can live meaningful lives is indicated by their participation in valued activities and by their sharing in the satisfactions of living.	8. The person with a disability is pitied and his or her life essentially devaluated.

Throughout social work intervention professionals should also be empathic, allowing the disabled person to explore and discuss feelings of pain, anger and despair.

Wright (1983:205-209) mentions several aspects which should be included in a rehabilitation programme so as to reinforce a disabled person's coping attitude. These aspects are:

- (i) Activities of daily living, for example: a paraplegic person being able to do a transfer from a bed to a wheelchair, or a stroke patient being able to walk with a cane, or to eat with a special built-up knife and fork. These activities force disabled persons to deal with present concrete difficulties and demands, helping to restore independence and self-respect.
- (ii) Sharing of success stories enhances the reality of successful coping.
- (iii) In seeing other people with disabilities manage, is a prime motivator in reinforcing a coping attitude.
- (iv) In the case where disabled persons have to use wheelchairs, crutches or artificial limbs, these aids should carry a message of coping and acceptance. For example a wheelchair need not look cheap or shabby, or an artificial limb can be made to look like a human

leg and not like a "stick".

- (v) A viewpoint of widening opportunities can enhance the belief that the "impossible" can be possible, granted that personal and individual assets are developed and the limitations and barriers (see social aspects in this chapter) are reduced.
- (vi) The use of brainstorming (that is a process of group problem-solving) helps disabled persons with the process of acceptance and coping with their disabilities.

In the context of coping, hope can be a sustaining force. However, Wright (1983:212) cautions that some disabled persons may use denial as a defence mechanism to cope with their disability. This can create a situation where disabled persons cling to hope in a unrealistic way. For example: the writer has had patients who tended to be over-religious, believing that God will heal them and that rehabilitation is unnecessary. The writer believes that hope and realism should be used with sensitivity and wisdom. Wright (1983:212) lists a few noteworthy guidelines:

- (i) Some hopes can be supported, some not.
- (ii) There should be a concentration on the here and now



situation; for the future new possible promising discoveries may be considered.

- (iii) Attention should be given to probabilities (which are important for planning), but also to possibilities (acknowledging far-fetched hopes and the lack of omnipotence of the professional).
- (iv) Hope can be supported where the disabled patient is making an active effort to cope, rather than passively succumbing.

Coping and acceptance of a physical disability, in the writer's opinion is interrelated and an ongoing process. Acceptance of a physical disability implies that a disabled person is comfortable with himself or herself, does not view a physical disability as devaluating and comes to terms with practical restraints. This attitude of mind is important in an employment situation because such an attitude helps the employer and colleagues to be at ease with the disabled person. Eventually it is a coping and accepting behaviour on the part of the disabled person that partly reduces the problem of stigmatization. Naturally the community and disabled persons have a right to demand an accessible environment (including housing and transportation) employment facilities as well as government financial aid and legislation to deal with the social problems of inaccessibility in its broadest sense.

### 2.3.3 Disability and Acceptance

According to Wright (1983:157-175) two major positive value changes are helpful and necessary in the process of acceptance, (the latter eventually reducing low self-esteem, shame and inferiority). The two value changes are:

#### (i) Enlarging the scope of values

(Wright, 1983:163). Some people with disabilities may be so pre-occupied with losses suffered and it is necessary to encourage a development of other values such as appreciation of life itself. To promote the development of other values, techniques of both individual work and groupwork can be used. Disabled people should be encouraged to regard life as meaningful granted that they use their remaining resources. The necessities of daily living and the hope of employment may help a disabled person to enlarge his scope of values. The satiation factor (that is becoming tired of an emotion) may also contribute to the enlarging of the scope of values; as Wright (1983:170) says:

"Satiation may be one important factor permitting a person 'to snap out' of a feeling of hopelessness and grief by him or herself."

The above implies that a disabled person eventually becomes tired of excessive depression and an ebbing of depression then occurs. Wright (1983:170) furthermore says:

"The dominance of loss is abated and, in searching for diversion, the person rediscovers the wider reality."

(ii) Subordinating physique relative to other values

(Wright, 1983:171). An increase in non-physique values can assist the disabled person in his/her process of acceptance of a disability.

This value change implies that the disabled person should regard personality (which includes kindness, effort, co-operation and intelligence) as more important than physical appearance. Another important aspect is that the disabled person should rather view his/her disability as an impaired tool and not as a personal characteristic. This will help the disabled person to realize that limitations may also be social barriers such as environmental barriers and discrimination. (The writer realizes that these social barriers can evoke feelings of bitterness and depression which needs working through either by individual therapy or group therapy.) The disabled person should also concentrate on asset values instead of comparative status values (that is: looks, background and capabilities.) Asset values imply that people are evaluated in terms of their intrinsic values and worthiness as a human being. In developing such a viewpoint the disabled person will hopefully realize that certain inabilities are not a devaluation of the self.

The writer feels that should disabled persons develop a positive, accepting and coping attitude towards life and should society accept people with disabilities and together strive to eliminate discrimination, create accessible transport and housing facilities as

well as the much needed retraining and training facilities and employment opportunities, there is no reason why integration of disabled persons into the community of South Africa could not become a reality.

#### 2.4 CONCLUSION

In chapter two the writer focused on the psycho-social aspects of a disability.

Since vocational rehabilitation is an important aim in the rehabilitation process, chapter three will attend to the role and task of a medical social worker in a vocational rehabilitation setting.

### CHAPTER THREE

#### WORKING WITH THE PHYSICALLY DISABLED : THE ROLE AND TASK OF THE MEDICAL SOCIAL WORKER IN A VOCATIONAL REHABILITATION SETTING

##### 3.1 INTRODUCTION

In this chapter the writer will focus on the role and task of the medical social worker in a rehabilitation setting where the emphasis is on vocational evaluation. This is often the second or third stage of rehabilitation where the patient's ability to work is assessed and he/she is helped towards appropriate work placement or training for suitable work. This would follow those stages of rehabilitation which are geared towards the emotional acceptance of the disability and motivation of the patient to becoming employed and learning to live as independently as possible. The writer, however, acknowledges that the medical social worker may have an important role in helping the disabled person to accept his/her disability.

In this chapter the writer will discuss tasks and roles of social work that are relevant to the nature of work in the vocational rehabilitation process.

### 3.2 THE GENERAL CONTRIBUTION OF SOCIAL WORK IN A REHABILITATION SETTING

Rusk (1964:284) states that social work services help to reduce the impact that associated problems may have on the disabled person and his family. It is therefore important that the social worker not only have a knowledge of individual and family reactions to such a crisis but also of all the available community resources and facilities that can be drawn upon to resolve the multitude of problems that may accompany the disability. The social worker therefore acts not only as a vital link between the disabled person, the rehabilitation setting and the community but also promotes the ultimate goal of rehabilitation viz the reintegration of the disabled person into his/her community.

### 3.3 THE ROLE AND TASK OF A MEDICAL SOCIAL WORKER IN A VOCATIONAL REHABILITATION SETTING

Compton and Galaway (1979:339-343) mention the various roles that social workers, despite the settings they work in, have to perform. These roles are those of:

- (i) Broker: In this role the social worker connects the client with a specific community resource. (Compton and Galaway, 1979:339).
- (ii) Enabler: The social worker helps the client to find coping strengths and resources in him/herself (Compton and Galaway, 1979:240). In a rehabilitation setting the social worker

should also assess the client's coping abilities prior to the trauma to ascertain whether the client has premorbid strengths to draw on. These include assessment of the patient's use of defence-mechanisms such as denial, rationalization and projection, as well as ego-strengths such as intelligence, intactness of senses, capacity to face reality, stability of mood, ability to control impulses, for example: anger, greed and to exercise self-discipline, capacity to accomplish age appropriate life tasks such as school, employment, marriage and social responsibilities, capacity to make mutually rewarding friendships and the evidence of a core value system such as a purpose in life, philosophy and/or religious faith. The social worker should also recognize the various strategies of As-If Behaviour, Idolizing normal standards, and Compensation as Indemnity (Chapter Two) which disabled persons use to improve their self-esteem. By recognizing the above-mentioned strategies the social worker can help the patient to develop positive coping mechanisms such as the enlarging of the scope of values and the sub-ordination of physique in relation to non-physique values. (Wright, 1983:157-175 and Nash et al, 1984:220-221, 265-266).

- (iii) Teacher: The social worker provides the clients with new information or new behaviour skills for coping with problems. (Compton and Galaway, 1979:340-341).

(iv) Mediator: This role may include the resolution of disputes between the client and other persons or organizations.  
(Compton and Galaway, 1979:342-343).

(v) Advocate: The social worker is the spokesman for the client by presenting and arguing the client's cause.  
(Compton and Galaway, 1979:342-343). For example: the medical social worker could liaise with a possible employer to appoint a rehabilitated disabled person.

Hardiker and Todd (1982:648) maintain that social workers have various roles in working with chronic ill people (or people with physical disabilities). These authors (1982:648) appropriately say:

"a range of roles may be required of social workers ..... ranging from counselor, enabler, advocate, to teacher and consultant."

Evans (1984:16-18) states that the social worker in vocational rehabilitation has a role of resource manager, whilst both Rubin and Roessler (1978:85-86) and Angell et al (in Moses and Patterson, 1971:66) mention that the social worker has a dual role of counsellor - co-ordinator. Furthermore, Rubin and Roessler see the social worker also as a case manager. Perusal of the above mentioned literature revealed that the above roles are interrelated. Furthermore, many of the tasks of the various roles correspond with one another.

The roles of social workers in vocational rehabilitation to be addressed are:



1. Counsellor/Case manager;
2. Co-ordinator/Resource manager; and
3. Team member.

### 3.3.1 The Role of Rehabilitation Counsellor/Case Manager

Allan (1958:67) maintain that counselling is a keystone in a rehabilitation programme for disabled persons. He goes on to say that the medical social worker is the person who most frequently counsel individuals with personal and family problems, acceptance of difficulties, utilization of community services, handling self-care, employment and general problems of adjustment to the disability.

A significant achievement in rehabilitation counselling has been the development and practice of the rehabilitation counsellor. According to the Professional Standards Committee in the United States of America (Moses and Patterson, 1971:70) rehabilitation counselling means helping the disabled person to cope with his/her disability to achieve self-realization and a productive life.

Angell et al (in Moses and Patterson, 1971:68) views the rehabilitation counsellor as a

"Problemsolver, operating on and continuously testing hypotheses related to individual clients. Group and individual counselling by self and others, education, training, and medical services all become treatment vehicles through which the counsellor assists the client in meeting his(her) needs."

From the above it is evident that the rehabilitation counsellor not so much applies a direct service per se, but may use various services

and resources in his endeavours to problem solve. Angell et al (in Moses and Patterson, 1971:68) would seem to confirm this when they state that

"..... the rehabilitation counsellor is viewed here as the rehabilitation strategist, the professional trained to sequencing treatment events."

Rubin and Roessler (1978:92) state that the tasks of a case manager (which are incorporated into the role of a rehabilitation counsellor) include:

- (i) Case finding
- (ii) Intake
- (iii) Diagnosis
- (iv) Eligibility determination
- (v) Plan development and completion
- (vi) Service provision
- (vii) Placement and follow-up
- (viii) Post-employment services

Rubin and Roessler (1978:93) stress the integration of the counsellor - case manager roles when they state:

"Working from the case-management model, the rehabilitation counsellor is a skilled professional at the "hub" of a multispeciality-oriented program requiring the co-ordination of many disciplines in order to meet the needs of the severely disabled."

The writer feels that the above applies equally to the moderately or mildly disabled persons.

### 3.3.2 The Role of Co-ordinator/Resource Manager

Rubin and Roessler (1978:86) agree that the social worker also has a role of co-ordinator. This role corresponds with Evans' (1984:16-18) role of resource manager when working with people with disabilities. Both these roles have similar tasks which are outlined in the following table:

TABLE 3.1: TASKS OF THE CO-ORDINATOR/RESOURCE MANAGER

EVANS: RESOURCE MANAGER	RUBIN AND ROESSLER: CO-ORDINATOR
(i) Social needs assessment	(i) Performing the intake interview.
(ii) Hospital discharge or community planning and brokering services of health care professionals and advocacy on behalf of the clients	(ii) Assembling of reports and management of cases.
(iii) Facilitating referrals.	(iii) Arrangement of services from other professionals.
(iv) Community resources development through the use of existing services.	(iv) Performance of public relations duties.

Rubin and Roessler (1978:86) mention a few other tasks:

- (i) Finding of cases.
- (ii) Determination of eligibility (that is: to determine whether the client could benefit from a specific rehabilitation service).
- (iii) Placement of clients in employment.

In the writer's rehabilitation setting cases are already found because patients are referred to the Rehabilitation Clinic. Although the eligibility of referred patients' are determined, placement of patients in employment does not exist because the Rehabilitation Clinic only focuses on vocational evaluation.

The role of co-ordinator/resource manager assures that the disabled person who has to rely on the health care system, receives the appropriate services in order to be rehabilitated as soon as possible.

The social worker can draw on her diagnostic and therapeutic knowledge in her role as resource manager/co-ordinator in her understanding of the patient's environmental problems. Adopting this approach, a psycho-social basis of intervention is ensured and there is a recognition of interplay between social and psychological factors (as discussed in the preceding chapter.) Although deeper psychological problems (for example: excessive pathological depression) cannot be ignored, the patient's psychological reactions to his/her disability such as anger, acting-out moody behaviour, lack of co-operation and non-compliance with the initial rehabilitation programme is regarded as a normal process of gradual acceptance and coping. The writer feels that the social worker should have the clinical knowledge, wisdom and sensitivity to decide whether a patient's behaviour is to be regarded as "normal" or pathological.

In the role of resource manager/co-ordinator, the social worker does not view the patient as being a victim of circumstances. A stance of

collaboration and reciprocity of influence is used between the social worker and the patient in that there is reciprocal responsibility for goal achievement. The patient is viewed as being independent and the emphasis is on action which helps link the patient with available community services. In this way the disabled patient is thus encouraged to utilize his/her own personal resources, helping networks and live a life of coping as discussed in the previous chapter.

Patterson, as reported in Rubin and Roessler (1978:86), feels that the roles of counsellor/co-ordinator should be separate ones but that, in practice, these roles are united into the role of counsellor. Whitehouse (1975) reported by Rubin and Roessler (1978:87) has a contrasting view. He sees the "rehabilitation clinician":

"..... as a professional whose skills include those of therapist, guidance counsellor, case manager, case co-ordinator, psychometrician, clinical life reviewer, vocational evaluator, educator, team member, social and family relater, placement counsellor, community advocate, life engagement counsellor, longterm conservator and clinician."

In practice, however, this dual role of counsellor/co-ordinator can cause role strain on the counsellor who has to deal with heavy case loads, lack of staff and responsibilities towards patients depending on her/him for guidance, correct referrals and counselling. The writer, in fact, herself has experienced the pressure of being counsellor/ case manager, having to cope with an overwhelming case load, as well as responsibilities towards the rest of the rehabilitation team.

Rubin and Roessler's (1978:89) research provides insight into the activities of a rehabilitation co-ordinator/counsellor:

"..... casework activities typified by information dissemination, information gathering, information processing, record keeping and service arrangement."

An analysis of the various tasks of the rehabilitation co-ordinator, together with a description of the various sub-roles, is necessary for a clear understanding of the extent of this role. Table 3.2 gives this analysis.

TABLE 3.2: A DESCRIPTION OF SUBROLE BEHAVIOUR CATEGORIES

SUBROLE	BEHAVIOUR DESCRIPTION
1. Information seeking - specific	Elicits specific factual information from clients regarding client background, e.g. work history, educational experiences.
2. Information giving - administrative	Informs the client about agency procedures and policies, the client's role in the rehabilitation process, appointments, etc.
3. Communication of values, opinions and advice	Communicates a) the subjective, personal and judgemental opinions of the counsellors, b) the counsellor's own personal past experiences, generalized to the client's situation, and c) a specific, suggested course of action.
4. Listening/client expression	Describes the portion of the interview where the content of client expression regarding concerns was predominant.
5. Information giving - educational and occupational	Communicates information of an educational or vocational nature.
6. Information seeking - exploratory	Elicits information in an open-ended, exploratory manner; elicits client's feelings and attitudes toward self, others, and past, present or future experiences.
7. Information giving - client based	Communicates information which pertains to the personal characteristics of the client, e.g. test scores, medical reports.

- |   |   |
|---|---|
| 8. Clarification, reflection and restatement          | Clarifies for the client what he has experienced difficulty in expressing clearly through synthesizing in a more simplified form, and/or by communicating to the client an understanding of the client's feelings and attitudes, or restating the content of a previous response. |
| 9. Friendly discussion - rapport building             | Develops rapport with the client permitting the client to experience being at ease in the interview.  |
| 10. Supportive  | Conveys the counsellor's acceptance, reassurance, and willingness to assist the client to discuss his problem; focuses on reducing the client's anxiety.  |
| 11. Information giving - structuring the relationship | Describes the structure of the client-counsellor relationship.  |
| 12. Confrontation                                     | Confronts the client with the reality aspects of the client's personality, discrepancies between the client's perception of himself and his actual behaviour.   |

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Source: Richardson et al (1973) (in Rubin & Roessler, 1978:91-92)

### 3.3.3 The Role of Team Member

The team approach is an important aspect in the current approach of psycho-social medicine as well as in the rehabilitation phase in medicine.

Watt (1985:192) maintains that

"Sharing the patient and his or her care (rehabilitation) must be a major goal of the medical (rehabilitation) interdisciplinary team."

From the above statement it is evident that the focus of the team approach should be on the patient and his or her future, and not on the status or roles of the various team members Alice Moore (Moses Patterson, 1971:309) sees the social work role as:

"the co-ordinator of the patient's total program. By training and experience, she has an overall view of the patient's needs and goals. She must be alert as to whether or not the program planned will result in more effective functioning for the patient."

From the above it is evident that the social worker acts on behalf of the patient. The social worker, in the opinion of the writer, also acts (as a mediator) on behalf of the rehabilitation team by explaining to the disabled person his/her diagnosis and prognosis (if not discussed previously); explaining the rehabilitation programme (including medical and vocational rehabilitation) and motivating the patient to comply with the rehabilitation programme.

The writer agrees with Allan (1958:121f) and Margolin (Moses and Patterson, 1971:329-333) that in order to foster harmony and understanding among team members, the social worker needs to acknowledge the competence, knowledge and experience of each team member - each a specialist in his/her particular field, be it occupational therapy, speech therapy, or any other discipline. Status-seeking and autonomy on the part of team members are decided liabilities in attaining the goal of effective planning for each individual patient. Emphasis is on the team approach and not on any particular person in that team. Clear and concise communication amongst team members is of vital importance, and there should be co-operation, co-ordination and integration of the various services which each team member provides.

The concepts of co-ordination and integration are often believed to be inter-changeable, whereas each in fact, has a different definition. Co-ordination implies harmonious adjustment and functioning, whilst integration is the process of uniting. Allan (1958:121) maintains that in teamwork there should be a co-ordination of services where each member works with the others, as



well as an integration of services which will unite the services provided for a common purpose and goal, namely a programme which will assist the disabled patient to advance as far as possible.

Having discussed the various roles and tasks of the social worker in vocational rehabilitation, it is now necessary to discuss the aspect of rehabilitation counselling.

### 3.4 REHABILITATION COUNSELLING

Rubin and Roessler (1978:99-100) mentions certain aspects relating to rehabilitation counselling, and it is appropriate to reflect on them:

- (i) Rehabilitation counselling is directed at preparing the disabled patient for job placement, and not at personality reconstruction which is the goal of psychotherapy. It can be "tempting" for the rehabilitation counsellor to become involved in psychotherapy, but the main goal of rehabilitation counselling is vocational choice and employment.
- (ii) Vocational counsellors have not been trained to conduct long-term psychotherapy and, bearing in mind the many and varied roles which rehabilitation counsellors already have to perform, it is essential that disabled patients with serious adjustment problems (as discussed in the previous chapter) are referred to psychotherapists to avoid rehabilitation counsellors having to contend with long-term psychotherapy situations.

- (iii) Rehabilitation counsellors need to involve the patient in the process of problem-solving as it affects vocational planning. This process can be regarded as a form of brief therapy with a vocational emphasis. Time-limited therapy need not be regarded as negative as it is usually goal orientated and productive, uniting patient and counsellor instead of allowing them to fall into the trap where the patient becomes dependent upon the counsellor.

Rubin and Roessler (1978:101-110) refer to Carkhuff's model of interpersonal helping as a basis for the counselling process to be used in rehabilitation counselling. Carkhuff's model implies that behaviour change can be obtained if there is a sequential movement through the three phases of exploration, understanding and action. The possible success of this model is based upon the creation of a warm, trusting relationship between patient and counsellor.

Carkhuff's model closely relates to the model for social work practice, proposed by Compton and Galaway (1979:244-245) namely the phases of contact (or engagement), contract and action.

In the contact phase of Compton and Galaway (1979) there is also a focus on the problem definition, but in comparison to Compton and Galaway (1979) Carkhuff (Rubin and Roessler, 1978:101-110) addresses the importance of the working relationship.

The contract phase mentioned by Compton and Galaway resembles the understanding-cognitive reorganization phase of Carkhuff (Rubin and

Roessler, 1978:101-110) in the sense that both models include the task of assessment in their specific phases.

Lastly, both models (that is Compton and Galaway 1979 and Carkhuff in Rubin and Roessler, 1978:101-110) have an action phase which include activities to be carried out.

The first phase in Carkhuff's model namely exploration-awareness, requires the accomplishment of two tasks. They are:

- (i) Clarification of the counselling relationship.
- (ii) Development of a therapeutic relationship.

For clarification of the counselling relationship, the counsellor needs to know the reason for the referral, the expectations of the patient, the patient's perception of the problem, and also the patient's relationship to the referral sources. These aspects are important as they can determine whether or not rehabilitation services should be rendered.

In order to develop the counselling relationship, it is necessary for the counsellor to explain the roles of counsellor and patient, and also to elaborate on the practical issues of anticipated time, place and duration of counselling sessions. The importance of a secure therapeutic relationship cannot be overstressed, as it serves as a communication bridge between counsellor and patient. It is only once the patient is able to feel safe in a non-threatening environment that anxiety can be decreased and the patient encouraged to share anxiety-arousing aspects with the counsellor.

Rubin and Roessler (1978:104) refer to Biestek, who mentions certain needs of the patient which have to be recognised in order to promote the development of a therapeutic relationship: The need to:

- (i) Be treated as an individual
- (ii) Express feelings
- (iii) Obtain a sympathetic response to problems
- (iv) Be recognized as a person of worth
- (v) Not to be judged
- (vi) Make own choices and decisions
- (vii) Keep secrets to oneself

A therapeutic relationship is not only conveyed in a verbal manner. It is also evident through non-verbal signs, such as tone of voice, body movements, direction of gaze, frowns, smiles and inflections. Possibly the most important consideration lies in the truth that the counsellor should remain civil, courteous, friendly and open. Old-fashioned good manners can surely determine the successful outcome of a relationship between patient and counsellor.

On its own, the exploration-awareness phase is not sufficient and a move needs to be made to the second phase, namely, that of understanding-cognitive reorganization. It is during this phase that the counsellor needs to focus on the patient's anxiety and problem-solving abilities. In the understanding phase, the counsellor needs to begin with an assessment of the patient's problem, implying that both counsellor and patient must clarify the patient's needs in terms of rehabilitation objectives, such as a

vocational goal, counselling, training or physiotherapy. Assessment should be performed towards four broad categories, namely:

- (i) Physical functioning.
- (ii) Psychological functioning (coping patterns and self-concept).
- (iii) Social functioning (including role performance, number of roles, role strain, communication, peer, family and group relationships).
- (iv) Work and environmental aspects (including social class, race, heritage and religion).

The assessment of a patient's problems or needs, in terms of the above mentioned categories reveals the complex interrelationship between the patient and his/her environment. Once an assessment of his/her needs and problems has been conducted, concrete goals need to be established for the patient. The "Working Diagnostic Statement" for concrete goals needs to incorporate:

- (i) An identification of problems.
- (ii) Diagnosis of psychological, social and environmental information.
- (iii) Tentative recommendations.

Once the "Working Diagnostic Statement" has been established, a rehabilitation plan can be formulated by both the counsellor and the

patient. Furthermore, can the patient's involvement in the rehabilitation plan not be over-emphasized.

By involving the patient in the development of his/her treatment plan, there needs to be a move to the last phase in the counselling process, namely, the phase of action or behaviour change. It is at this time that the counsellor will involve the patient in the plan of action. In order to do this, the counsellor may either need to communicate directly with the patient and his/her significant others, or to render indirect services, such as liaising with other community services.

In direct communication with the patient, the counsellor should deliberately focus on reinforcing those behaviours which are necessary for the accomplishment of the vocational goal. Such reinforcement can be verbal, gestural, or even symbolic.

Environmental problems which affect the patient should also be addressed, because, if not attended to, they could hinder the patient's achievement of successful vocational rehabilitation. Invariably, environmental problems are handled through indirect services, on behalf of the patient.

During the phase of action or behaviour change, the counsellor also needs to formulate the treatment process, which has certain specific phases, namely:

- (i) Delivery of services.
- (ii) Co-ordination of services.
- (iii) Monitoring of client's progress.

The counsellor also has the task of preparing the patient for termination of treatment.

Rubin and Roessler (1978:110) believe that a patient can be considered as successfully vocationally rehabilitated if the patient has been satisfactorily employed for at least 60 days. Although this dissertation does not focus on this aspect, it is interesting to note that another trend has emerged, namely, that rehabilitation needs to include the aftercare and long-term maintenance of employment by the development of post-employment services. In the writer's particular vocational setting, facilities for vocational rehabilitation are at present so inadequate that post-employment services can only be acknowledged as a well-needed service for the future.

It has been mentioned that, during the first phase of the rehabilitation counselling process, assessment is an important task of the counsellor. As thorough assessment determines correct vocational choices and services to be rendered, it seems appropriate to focus attention on the intake interview, which is usually performed by the rehabilitation counsellor (social worker).

During the intake interview, the patient's social history is gathered in order to determine whether he/she can benefit from the specific

rehabilitation setting. If a patient is accepted in that setting, he/she will participate in medical examination, psychological examination and a work evaluation. This four-faceted evaluation process serves as a guide for the composition of a suitable rehabilitation plan for the patient.

The intake interview has various goals, namely:

- (i) Determination of the patient's reasons for seeking help.
- (ii) Explanation of the role and function of the rehabilitation setting.
- (iii) Development of rapport between patient and counsellor.
- (iv) Gathering of information.
- (v) The explanation of evaluation procedures and the reasons for them.

The intake interview is the foundation for further planning, and to ascertain that all relevant data is obtained it is advisable for a guideline to be followed when assisting the patient through this interview. Such a guideline (Rubin and Roessler, 1978:131f) ensures that the interview is conducted systematically:

**TABLE 3.3: GUIDELINE FOR INFORMATION COLLECTION AT INTAKE INTERVIEW**

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**I Physical Planning**

- a. What specific impairments are present?
- b. What caused the disability?
- c. How long has client been disabled?
- d. Has the client received any disability related treatment in the past (e.g. physical therapy)?

continued / ...



- e. Has the client's disabling condition become worse over the last year?
- f. Is the client receiving treatment for the disability?
- g. Are there recent medical test results available on the client that are relevant to the question of extent of physical impairment?
- h. In what manner and to what extent is the client's physical disability handicapping in regard to daily functioning?

## II Vocational Skills

- 1. **Educational history**
  - a. How far did the client go in school?
  - b. What did the client like or dislike about school?
  - c. Why did the client leave school (Graduate, other)?
  - d. If the client did not complete high school, has he/she passed a high school equivalency exam?
  - e. Has the client had any specific type of vocational training which prepared him/her to enter a particular occupation?
- 2. **Work history**
  - a. What were the last 3 jobs held by the client?
  - b. For each of those jobs:
    - (i) How much was earned weekly?
    - (ii) Length of employment (Was it long enough to acquire specific skills?)
    - (iii) Time since job held (Has sufficient time passed for significant skill loss to take place?)
    - (iv) What aspects of the job could the client do best?
    - (v) What aspects of the job did the client perform poorly?
    - (vi) What aspects of the job did the client like most?  
Why?
    - (vii) What aspects of the job did the client like least?  
Why?
    - (viii) Reason for termination of employment.
    - (ix) How well did the client get along with his/her supervisor?
  - c. Prior to onset of his disability, were there any significant interruptions in his work history? Why?
  - d. Is the client presently unemployed? If yes, how long?
  - e. Has the client been employed since onset of disability?

## III Psychological Functioning

- a. Does the client have any fear of competitive situations?
- b. Does the client have any fear of social exposure of his/her disability?
- c. Does the client have any fear of overexertion?
- d. Are there any recent psychological test results available on the client which are relevant to the question of client psychological adjustment?
- e. Is there any agency or professional from whom the client is presently receiving psychological services?

continued / ...

- f. Has the client ever received professional treatment for a personal adjustment problem?
- g. Is the client taking any tranquilizers or sleeping pills?

#### IV Environmental

- 1. Relationships with family and friends
  - a. What is the client's marital status?
  - b. Is the client living with his/her family
  - c. Does the client have any dependent age children?
  - d. Will the most significant family members (i.e. wife) be supportive of the client's rehabilitation plan?
  - e. How does the client feel about his/her home environment?
  - f. How does the client get along with other family members?
  - g. Does the client have any close friends?
  - h. Is the client satisfied with his/her social life?
  - i. How does the client fill the hours of the day?
- 2. Economic situation
  - a. What is the client's primary source of support?
  - b. In addition to this primary source of support, does the client have other sources of support?
  - c. Does the client have any unpaid debts of significant size?
  - d. Are there any current fixed living expenses such as medication expenses which cannot be reduced?
  - e. Does the client have a workman's compensation case pending?
  - f. Is the client receiving welfare or SSI benefits?
  - g. Does the client have any medical insurance?
  - h. Is the client concerned about his/her economic situation?

#### V Personal Vocational Choice Considerations

- a. Is the client interested in vocational training?
- b. Is the client interested in any specific type of vocational training?
- c. Does the client have a specific vocational objective?
- d. Does the client have more than one potential vocational goal?
- e. How optimistic or pessimistic is the client about achieving each of the vocational goals?
- f. What does the client see himself/herself doing vocationally five years from now?
- g. What minimum salary would the client consider?
- h. Does the specific job task matter to the client?
- i. Does the client prefer to work collaboratively with other people or independently?
- j. Is the client willing to relocate geographically to acquire work?

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Source: Rubin & Roessler (1978:131-133)

It is important to remember that the intake interview should be used

to get to know the client, and not merely for the sake of information. The intake interview requires that the counsellor develops an ability to integrate information so that a clear picture results and understanding of the patient and his situation is evident.

A patient's lack of motivation is a common subject for discussion. Moses and Patterson (1971:126-129) refer to Patterson, who is of the opinion that no human being can be totally unmotivated. Patterson feels that the problem is rather that the patient has goals which are not shared by the counsellor. These goals are usually related to the patient's self-concept and, therefore, the counsellor is faced with the task of not changing the patient's goals but, rather, changing the patient's self-perception.

For example: The writer recalls two mildly disabled patients who approached the Rehabilitation Clinic for a disability grant. Both these patients are from the lower economic strata and understandably viewed a disability grant as a form of financial security.

Furthermore, were both these persons, the one suffering from lower backache and the other having a shorter leg due to childhood polio, convinced that they were unable to work. During the intake interview the writer explained the worth of vocational evaluation, as well as the options of sheltered employment and practical help in obtaining open labour-market employment. The writer also stressed the patients' positive characteristics. Both these persons attended vocational evaluation. Eventually one patient was referred to the

Rehabilitation Centre of the Association for the Physically Disabled, for vocational training for the open labour-market. The other patient was found eligible for sheltered employment. In the writer's opinion these two examples reveal the importance of vocational evaluation in contributing to the development of a positive self-esteem which is important for successful employment.

It has to be accepted that people resist change when facing the unknown, so if a change in a patient's perception is needed, the patient needs to feel accepted and non-threatened by the counsellor. Threat, coercion and pressure are negative techniques if one wishes to motivate a patient.

A change in self-perception is sometimes a lengthy and tiring process and success is not guaranteed with each patient. However, it is important to remember that when faced with patients who present as deceitful, malingering, insincere and manipulative, counsellors have to be understanding. Acceptance of this type of patient is a basic necessity for the creation of an atmosphere where motivation can be facilitated.

When endeavouring to motivate a patient, Wright (198:417-441) suggests that the patient should be viewed as a co-manager. This implies active participation on the part of the patient, and not merely a co-operative attitude. Traditionally, the team has always interacted without the most important member (the patient) being present. It is recommended that, where possible, patients should be

encouraged to become an integral part of team meetings, as this is an important principle of patient management. Dignity is extended to the patient by including him/her in team meetings. Wright feels that although some professionals may fear that the patient could be emotionally hurt when discussed, an open, honest, caring and respectful discussion can actually do no harm. It could even be that the co-management approach may act as an impetus for motivation, willpower and co-operation on the part of the patient.

In her role as rehabilitation counsellor, the social worker can draw on some of the well-known treatment approaches currently practised. Although the writer is not discussing these approaches per se a few will be discussed to highlight their usefulness in augmenting the rehabilitation process.

### 3.5 APPROACHES IN REHABILITATION COUNSELLING

As previously mentioned in this chapter, rehabilitation counselling does not focus on adjustment problems, acceptance of and coping with the disability. (Rubin and Roessler, 1978:99-100). However, Thomas and Butler (in Parker and Hansen, 1981:227) maintain

"Problems associated with disability are rarely limited to the finding and retention of appropriate employment. In recognition of this fact ..... and roles of the rehabilitation counsellor include the resolution of client adjustment problems that may or may not impinge directly on the client's ability to work."

Thus, in comparison to Rubin and Roessler's (1975) viewpoint, Thomas and Butler (in Hansen and Parker, 1981) maintain that the

rehabilitation counsellor should also attend to personal problems such as acceptance of the disability, stigmatization, inaccessible environment and changes in interpersonal relationships as discussed in preceding chapters. The writer, however, agrees with Rubin and Roessler (1978:99-100) that patients with serious adjustment problems such as depression, and anxiety should rather be referred to psychotherapists.

### 3.5.1 Individual therapy

Thomas and Butler (in Parker and Hansen, 1981:227-253) recommend various approaches which can be used in individual therapy. Some of the approaches recommended by them are:

- (i) The Client-centred Therapy of Rogers (in Parker and Hansen, 1981:27-28).
- (ii) Rational-emotive Therapy (RET) developed by Albert Ellis (in Parker and Hansen, 1981:244-246).
- (iii) Reality Therapy of Glasser (in Parker and Hansen, 1981:246-247).

Thomas and Butler (in Parker and Hansen, 1981:25) however, maintain that no specific counselling theory provides a solution for all types of problems. Furthermore, all clients with similar problems do not always respond positively to the same type of counselling technique. Thomas and Butler (in Parker and Hansen, 1981:252) maintain that an eclectic approach allows counsellors to use a variety of techniques based on various theoretical systems, provided that they are logically integrated and contextually appropriate.

### 3.5.2 Group therapy

Thomas and Butler (in Parker and Hansen, 1981:255) endorsed by Bass (Moses and Patterson, 1971:182) maintain that group therapy can be utilized successfully in a vocational rehabilitation setting.

Thomas and Butler (in Parker and Hansen, 1981:255) hold the opinion that group therapy allows for a more efficient use of time. They furthermore agree that group therapy facilitate the exchange of feelings such as despair, frustration and depression as well as the solving of practical problems such as housing, inadequate finance and unemployment. Thomas and Butler (in Parker and Hansen, 1981:255) go on to say that the therapeutic group can also serve as a support system in the process of acceptance of and coping with a physical disability as discussed in chapter two.

Bearing the above in mind, the writer is of the opinion that group therapy can be used in the development of a disabled person's work personality - the latter having been discussed in the previous chapter.

The group therapy goals listed by Bass (Moses and Patterson, 1971:186) are endorsed by Yalom (1975:11). In fact, a similarity exists between the curative factors listed by Yalom (1975:11) and the group therapy goals listed by Bass (Moses and Patterson, 1971:186) in relation to vocational rehabilitation. The similarities are summarized in Table 3.3.

TABLE 3.4: GROUP THERAPY GOALS

BASS	YALOM
(i) Development of satisfactory inter-personal relations.	Development of socializing techniques.
(ii) Social skills.	Interpersonal learning.
(iii) Feelings of confidence and self-worth.	Instillation of hope/universality.
(iv) Relief of anxiety with regard to vocational adequacy.	Catharsis/Instillation of hope.
(v) Proper work attitudes	Interpersonal learning.
(vi) Seeing oneself in the role of worker and learning appropriate role behaviour.	Imitative behaviour/ Interpersonal learning.
(vii) Development of greater spontaneity of communication.	Catharsis/Imitative learning/Interpersonal learning.

Bass (Moses and Patterson, 1971:184) maintains that in group therapy the individual members of the group can become "therapists" for each other. In the group situation, the reality of life is represented and it is experienced in such a non-threatening, therapeutic atmosphere that group members interact spontaneously with one another, and biased self-perceptions are modified. Acceptance and support amongst group members is also known to be of more benefit than can ever be gained from the counsellor in a one-to-one therapeutic relationship.

The above mentioned viewpoint is endorsed by Yalom (1975:13) when he says:



"..... patients are enormously helpful to one another in the group therapeutic process. They offer support, reassurance, suggestions, insight and share similar problems with one another."

Bass (Moses and Patterson, 1971:184) furthermore says that as group members take responsibility for one another, problem-solving methods for individual problems can be developed within the peer group, without any resistance being offered by the members concerned. The rationale for this is that group therapy counteracts helplessness, desperation and isolation.

The technique of role playing in group therapy can be successfully used, especially amongst lower socio-economic groups. (Bass, in Moses and Patterson, 1971:184). A reason for this is that people from the lower income group tend to act out of their feelings and by creating the opportunity for them to act out of their anxieties, disabled patients are able to enhance their feelings of self-confidence and adequacy.

As disabled patients confront the realities and responsibilities of everyday life, an important focus of group therapy should be on the "here and now" struggle of life. Attention should be given to interpersonal relationships, communication, interaction and coping mechanisms in a variety of situations - whether the vocational setting or within the family environment.

The successful use of group therapy in vocational rehabilitation is aptly summarized by Thomas and Butler (in Parker and Hansen, 1981:225).

"Since clients (people with disabilities) are often convinced that they are the only ones with particular concerns or feelings, the sharing of feelings can be an especially beneficial aspect of the group process."

Although group therapy cannot totally replace individual therapy (Thomas and Butler in Parker and Hansen, 1981:255) the writer has the opinion that group therapy, used in conjunction with individual therapy, can facilitate personal adjustment.

### 3.5.3 Family therapy

Although Power and Dell Orto (1980) have the opinion that family therapy should form an integral part in the rehabilitation programme of disabled persons, the literature on vocational rehabilitation which the writer has perused does not refer to the use of family therapy.

As discussed in Chapter Two, the writer agrees with Power and Dell Orto (1980) that family therapy with disabled persons is important. However, the impression is gained that Power and Dell Orto focus on the acute phase of medical rehabilitation, severely disabled persons, families with a history of pathological functioning and families who have problems in the acceptance of and coping with a severely disabled family member.

Bearing the above in mind, the writer feels that, should it become evident during the vocational rehabilitation phase that a family is having problems with the acceptance of and coping with a disabled family member, family therapy should be considered as part of the rehabilitation programme.

Munro (1985:18f) mentions important behavioural patterns in families which should alert the social worker to intervene:

- (i) Loud chronic complaining.
- (ii) Programme sabotage.
- (iii) Extreme overprotectiveness.
- (iv) Hypochondriacal obsessions (referring to family members who constantly focus on somatic problems).
- (v) Open warfare in families.
- (vi) Symbiotic relationships (that is pathologically close relationships).
- (vii) Avoidance of the disabled person.
- (viii) Psycho-social deprivation of families.

Munro furthermore (1985:24f) discusses some noteworthy intervention procedures:

- (i) The focus should be on the here-and-now.
- (ii) If possible humor could be used.
- (iii) The social worker should be sensitive and empathic.
- (iv) The social worker should be aware of counter-transference (that is strong emotional reactions in the professional that is counter-therapeutic).
- (v) Supportive techniques include privacy, creating of a relaxed atmosphere, promises/commitments to the family should be adhered to, grievances should never be treated lightly, and "permission" could be given to family members to participate

in social activities they never allow themselves; for example to plan a vacation without the disabled family member.

- (vi) Confrontational techniques is needed when a family reacts by manipulation, bargaining and persuasion. Confrontational techniques can include strict communication rules (for example family members are not allowed to interrupt one another), formal meetings with high profile agency representatives to discuss or to review the rehabilitation programme (especially when a family is sabotaging a disabled person's rehabilitation programme) and paradoxical intervention (that is intervening in an absurd manner to dissolve the unrealistic family behaviour.)

### 3.6 CONCLUSION

In Chapter Three the following aspects were addressed:

- (i) The various roles and tasks of a medical social worker in a rehabilitation setting.
- (ii) Rehabilitation counselling.
- (iii) Certain therapeutic approaches used in individual therapy, group therapy and family therapy in relation to rehabilitation counselling.

In Chapter Four the focus will be on the Rehabilitation Clinic at Karl Bremer Hospital, Bellville, describing the practice of social work in this specific clinic so as to give an example of social work in a vocational evaluation rehabilitation setting.

PART TWO

REHABILITATION IN PRACTICE

## CHAPTER FOUR

### THE REHABILITATION CLINIC AT KARL BREMER HOSPITAL, BELLVILLE, CAPE

#### 4.1 HISTORICAL OVERVIEW OF THE REHABILITATION CLINIC

The origin of the Rehabilitation Clinic dates back to 1959 when Dr J.C.S. Steytler, (former head of Rehabilitation Medicine at the Medical School of the University of Stellenbosch) and Dr R.C.M. Kotzé (former Medical Superintendent of Karl Bremer Hospital, and former Director of Hospital Services in the Cape Province) formed two committees to render rehabilitation services.

These two committees were

- (i) Re-enablement Committee (Herbekwamingskomitee). This committee, chaired by Dr Steytler focussed on self-help and activities of daily living with regard to the disabled person, as well as "work-training".
- (ii) Re-settlement Committee (Hervestigingskomitee). Under the guidance of Dr Kotzé this committee endeavoured to integrate disabled persons back into the community.

The above mentioned committees held regular meetings with the Department of Manpower, the Orthopaedic Workshop and the Association for the Physically Disabled (formerly known as the Cripple Care Association) to co-ordinate services, discuss disabled patients and request possible job placements for the patients concerned.

Unfortunately at some stage (the specific date is unknown) these committees were terminated because of other vocational responsibilities that both Drs Steytler and Kotzé had to attend to.

However, in 1974 with the opening of Tygerberg Hospital as a training hospital, Dr Steytler was requested to recommence rehabilitation services and a formal rehabilitation service was formed under the auspices of the Department of Community Health of the Medical Faculty of the University of Stellenbosch. With this development a Rehabilitation Committee was formed in 1974. This Rehabilitation Committee's goal was to rehabilitate disabled patients, who had the potential to work, on a physical and emotional level in order to achieve their maximum potential in an employment situation. They established out-patient rehabilitation clinics to which patients could be referred. Rehabilitation Committee meetings were held to discuss patients and draw up a rehabilitation programme which included several vocational options as discussed in Chapter One. Noteworthy was the establishment of a resettlement officer (a social worker) with the task of job placement. Unfortunately this post was later terminated.

As the Rehabilitation outpatient clinic expanded, weekly team meetings became a necessity and in 1985 the Rehabilitation Committee was disbanded because its function was duplicated by the team meetings of the rehabilitation out-patient clinics.

#### 4.2 FUNCTIONING OF THE REHABILITATION CLINIC

In 1987, as a result of The Year of the Disabled Persons (1986), Karl Bremer Hospital became a rehabilitation hospital. Therefore the Rehabilitation Clinic was relocated at Karl Bremer Hospital. Furthermore two rehabilitation wards were also opened at this hospital.

The Rehabilitation Clinic's major goal is still that of vocational rehabilitation. Specific services are rendered to accomplish vocational rehabilitation. They are:

- (i) Vocational rehabilitation, in the form of work assessment by the Department of Occupational Therapy at Tygerberg Hospital.
- (ii) Physical rehabilitation by means of physiotherapy, occupational therapy and/or speech therapy for all ages.
- (iii) Services with regard to prostheses and orthoses.
- (iv) Pastoral care.
- (v) Social work services.
- (vi) Clinical psychology services, mainly psychometric assessment.

The Rehabilitation Clinic at Karl Bremer Hospital acts as a co-ordinating clinic where patients are referred to the appropriate



rehabilitation services such as vocational assessment or physical rehabilitation services for example the Orthopaedic Workshop for orthopaedic appliances. The social work services also include appropriate referrals of disabled persons to community resources such as the Association for the Physically Disabled for training services, support and general after-care services.

The multi-disciplinary approach is still utilized to monitor patients' progress and to formulate and implement a realistic plan of action.

At present patients have various employment options such as those discussed in Chapter Two. To recap, the various options are:

- (i) Placement in the open labour market.
- (ii) Placement in sheltered employment.
- (iii) Placement at protected workshops.
- (iv) Referrals for further training: for example to the Rehabilitation Centre of the Association for the Physically Disabled. In these cases, disabled persons usually have the potential for work in the open labour market, but they need pre-vocational and vocational training as explained in preceding chapters.
- (v) Referrals to community support groups such as stroke clubs and sport clubs for disabled persons. The reason for such referrals is to enrich disabled persons' quality of life, to prevent isolation and to ensure a support system.
- (vi) Application for permanent disability grants.

- (vii) Application for temporary disability grants, in order to provide a disabled person with the opportunity to complete his/her specific rehabilitation programme.
- (viii) Teaching certain disability grant pensioners some home industries which not only can be seen as life enrichment, but can also produce an additional income for themselves.

The services of the Rehabilitation Clinic are handicapped by two problems:

- (i) The vocational evaluation area of the Occupational Therapy Department is situated at Tygerberg Hospital. This situation creates a fragmentation of services, a lack of effective teamwork and team communication.
- (ii) The lack of a placement officer (who in the opinion of the writer should be an occupational therapist) to assist with placement and follow-up work. Due to cuts in the government budget, the current occupational therapist is overloaded with work and is unable to attend to the above mentioned aspects.

The writer feels that the other phases of vocational rehabilitation should also be included in the current vocational services of the Rehabilitation Clinic to ensure continuity of services and prevent fragmentation of services.

The Rehabilitation Clinic has expanded tremendously since 1975. Statistics indicate patient increases in that whereas 245 patients attended in its first year of existence, 1 032 patients attended the Rehabilitation Clinic in 1987.

#### 4.3 FUNCTIONING OF THE MEDICAL SOCIAL WORKER

There has been no fulltime social work post at the Rehabilitation Clinic from the time it was established. Until 31 March 1987 social work services were rendered by a social worker (the writer) who was seconded from Tygerberg Hospital. From 1 April 1989 a social worker from the Day Hospital Organisation is rendering services to the Rehabilitation Clinic.

Disabled persons are referred to the social worker in the following circumstances:

- (i) Social work assessment based on an abbreviated version of the Maudsley History Schedule (Departments of Psychiatry and Child Psychiatry at the Institute of Psychiatry and the Maudsley Hospital, London, 1987:1-22) especially when the patient is being referred for work assessment. At the end of an assessment, the writer should be able to conclude whether a patient has rehabilitation potential or not.
- (ii) Obtaining collateral information, especially where a patient's integrity is questioned. Usually family member's are requested to provide collateral information.

- (iii) When the medical officer has identified social problems, namely, financial, unemployment, alcoholism, interpersonal relationships, marital, child abuse, delinquent children, inadequate food, shelter or clothing, emotional problems (in the case of severe, pathological emotional problems patients would be referred to the Department of Psychiatry, Tygerberg Hospital), or problems of non-compliance with medical treatment.
- (iv) Motivation of patients for rehabilitation, specifically with regard to vocational rehabilitation. Patients who are referred to the Rehabilitation Clinic have usually been without employment for long periods and view themselves as unfit for work and their main interest appears to be that of obtaining a permanent disability grant.

In motivating the patient, the writer explains the importance of employment for increasing self-worth and self-esteem, and outlines the opportunities which are available namely, sheltered and protected employment or home industries. The concept of work assessment is also explained and patients are encouraged to participate in the work assessment phase of the rehabilitation programme. The patients are also prepared for psychometric tests and are told about the team meetings and assured of confidentiality.

Family members are also included wherever possible with a view to explain the rehabilitation programme and request compliance with the programme or to render counselling services with regard to interpersonal relationship problems. However, these family interviews cannot be regarded as family therapy per se.

The under-utilization of family therapy is perhaps due to a heavy work load, the emphasis on assessment, the fast tempo of an out-patient clinic, and transport costs. The cost of transport must not be underestimated, particularly where patients are unemployed and have no income. In such circumstances, disabled persons may tend to worry about financial issues, rather than family problems. If there is no money for food, then how can one realistically expect the whole family to find money for transport to visit the social worker. Furthermore, a lack of psychological awareness may also contribute to the lack of discussing emotional or family problems.

Due to the pressure of work, additional individual interviews with a therapeutic objective are only conducted with those patients who are in need of additional support and attention. In the case of more severe pathological problems, where there is a need for long-term psychotherapy, patients are referred to the Department of Psychiatry. As many patients suffer from problems of alcohol abuse, the writer uses the brochures supplied by the South African National Council for Alcoholism (SANCA) (Item 3 in the Appendix) to assess the patient for alcoholism. Further action is based on the results of this assessment.

The writer refers patients who suffer from severe social, emotional and interpersonal problems to available community resources, such as private welfare organizations and support groups, who provide the necessary support, guidance, counselling and supervision. Feedback is requested in order to ensure that the Rehabilitation Clinic is always aware of the patient's condition and circumstances. In turn, the community resources are made aware of the Rehabilitation Clinic's support and help, should this be required.

Encouraged by and required for post-graduate studies, the writer initiated a ten session group therapy programme for a selected group of disabled persons during August - October 1987. The persons involved reported an improvement of their emotional state of mind, which encouraged participation in further rehabilitation services such as vocational evaluation with the objective of future employment. Based on this positive feedback, a six session group therapy programme was repeated during February - March 1988.

However, the writer experienced that the Rehabilitation Clinic's client group is not familiar with therapeutic group therapy and that it is more advantageous to return to a programme of eight to ten weeks duration. It was found that the patients of the Rehabilitation Clinic learn slowly and that it took approximately five to six weeks before they became familiar with group therapy and feel sufficiently secure to move into the therapeutic phase of problem-solving.

During team meetings the writer plays a co-ordinating role by giving verbal feedback on patients and keeping records in both the social

work file and Rehabilitation Clinic file on the progress, planning and implementation of the rehabilitation programme of each patient. Duplicates of correspondence (both outgoing and incoming) are filed in both the previous mentioned files. This ensures that all team members are informed about a person's progress and social circumstances. Furthermore telephone or personal interviews are also noted in both social work and rehabilitation clinic files for the above mentioned reason.

As discussed in Chapter Three, it appears that the writer's involvement in a rehabilitation clinic can be related to the following roles:

- (i) **Rehabilitation Counsellor**, which involves the specific tasks of assessment, motivation and supportive therapy, where required, as well as group therapy.
- (ii) **Case Manager and Team Member**, with the task of integration of services.
- (iii) **Co-ordinator of Services**, which overlaps with the role of case manager.
- (iv) **Resource Manager or Broker**, with the task of referring patients to appropriate community resources. The role of resource manager may overlap with the role of case manager.

The following statistics indicate to what extent social work services expanded:

- (i) In 1982, a total of 245 patients received attention from the social worker. Unfortunately, no distinction was made between newly referred patients and follow-up activities rendered to patients.
- (ii) In 1986 the writer attended to 250 new patients and 897 follow-up activities to Rehabilitation Clinic patients.
- (iii) In 1987 attention was given to 225 new patients and 1 043 follow-up activities were rendered to clinic patients.

#### 4.4 CONCLUSION

Having discussed the functioning of the Rehabilitation Clinic as it affects the functioning of the social worker, Chapter Five will deal with the methodology and research done by the writer.



## CHAPTER FIVE

### RESEARCH METHODOLOGY

This chapter will discuss the research methodology utilized in the study.

#### 5.1 OBJECTIVES OF THE STUDY

5.1.1 This study aims to provide guidelines for the social work role and task at the Rehabilitation Clinic at Karl Bremer Hospital in an attempt to improve social work services at the above-mentioned clinic.

The study aimed to achieve this by

5.1.2 describing the psycho-social characteristics of patients referred to the social worker in order to determine the extent to which these influenced her intervention and also

5.1.3 to describe and assess the social work services rendered in terms of the theory discussed in preceding chapters.

## 5.2 RESEARCH METHOD

The research method used is a descriptive one because psycho-social characteristics of patients and social work interventions are described to ascertain whether a causal relationship between patient characteristics and social work interventions exists (Polansky, 1975:49). The study was also retrospective in that material was extracted from social work records of interviews conducted with the sample group.

## 5.3 PREMISE OF THE STUDY

The underlying premise of this study is that psycho-social characteristics of physically disabled persons influence the role and task of the medical social worker involved in vocational rehabilitation.

## 5.4 METHOD OF STUDY

### 5.4.1 Sample

A random sampling was drawn from the total group of 90 patients referred to the writer during the period 1 July 197 - 1 December 1987. This period was chosen as the writer introduced a new assessment interview format adapted from the Maudsley History Schedule (Departments of Psychiatry and Child Psychiatry at the Institute of Psychiatry and the Maudsley Hospital, 1987:1-22). Every second name was selected from an alphabetical list of the patients to form the sample group of 45 patients. By using simple random

sampling (Cozby, 1981:123) an attempt was made to ensure that each referred patient has an equal chance of being selected for the sample group and therefore can be representative of referred patients to the clinic.

#### 5.4.2 Limitations of the study

The use of patients referred to the writer during the above-mentioned period effects the validity and reliability of the study. This is because the results cannot be generalized as such as they may not be that representative of all patients needing vocational evaluation. To the extent that the social work role is defined as work undertaken with these patients only, the resultant definition of the social work role and tasks may be limited. The use of retrospective information effected the validity of the results because the writer experienced that many case records were incomplete.

### 5.5 RESEARCH TOOLS

#### 5.5.1 Review of the literature

An extensive review of both local and international literature was undertaken by consulting catalogues, the psycho-info data base and the Human Science Research Council in South Africa. The writer was especially interested in tracing literature that related to vocational rehabilitation as this is the focus of work undertaken at the Rehabilitation Clinic where the writer was employed.

#### 5.5.2 Data collection

Two structured schedules were compiled so that information from the files could be collected according to various categories.

Information was extracted from both the Social Work and Rehabilitation Clinic files. Schedule 1 was structured to determine various demographic and psycho-social characteristics about the patients. The categories included identifying particulars with regard to the patient (including his/her marital status), medical diagnosis, his/her family situation, interpersonal relationships, socio-cultural characteristics, educational status, work history, financial status, accommodation, criminal record substance abuse and personality problems.

Schedule 2 was used to determine the nature of social work services rendered to the patients. The categories included were based on the writer's experience at the Clinic, on generic social work literature such as Compton and Galaway's Social Work Processes (1979) as well as on the literature discussed in Chapter Three of this study.

According to the writer it seemed logical to obtain information on the psycho-social problems identified, frequency of social work interviews and contacts with various resources, as well as the various roles and tasks undertaken by the writer. The various tasks were categorized as the following interventions: assessment, therapeutic interventions (individual therapy and group therapy), obtaining of collateral information, referrals to various resources (for example: government departments, private welfare agencies, institutions and community resources). A question on the utilization of the team approach was also put in because the team approach is regarded as an important facet in rehabilitation as previously discussed.

In using schedules to extract information from archival data, a retrospective study was done, the latter having limitations which will be discussed later in this chapter. The writer in fact was forced to use archival data because of the following problems:

- (i) Some patients live in the country and cannot be easily reached.
- (ii) Some patients do not have telephones and could not be called in for personal interviews.
- (iii) Some patients do not have permanent addresses, frequently change their abodes, and therefore cannot be traced.
- (iv) Most patients live in areas made dangerous by criminal and other activities. In fact, the writer was warned not to enter these areas alone.
- (v) Vocational circumstances. Lack of staff prevented personal follow-up interviews, because should the writer perform personal interviews by visiting the patients, no social worker was available to render the necessary day-to-day social work services.

## 5.6 SCHEDULE ADMINISTRATION

### 5.6.1 Testing the schedules

The writer acknowledges the mistake not to test the schedules by means of a pilot study. This resulted in unnecessarily lengthy schedules, revealing irrelevant information. Had a pilot study been done to test the schedules, time and work could have been used more productively.

### 5.6.2 Administration of the schedules

Both schedules were completed manually by the writer herself. This lengthy task implied the reading through of both the Rehabilitation Clinic in-patient file and the social work file. The use of both the above mentioned files was an attempt to increase the validity and reliability of the study because some of the information in both files corresponded and/or supplemented one another.

### 5.6.3 Limitations of the schedule administration

- (i) As mentioned above, especially schedule 1 which deals with the psycho-social characteristics of patients referred to the social worker (the writer) was too lengthy and included certain irrelevant questions. These irrelevant questions were a hinderance to obtain the realistic psycho-social characteristics of the sample group. Furthermore valuable time was wasted. Time was also wasted by the lack of research help and no access to computer facilities.

- (ii) The fact that only the writer completed the two schedules, could leave room for a lack of standardization of data collection and researcher bias. That implies, should a second researcher complete the two schedules that it could well lead to different interpretations of the archival data and the questions. (Blalock, Hubert, M. Jnr., 1970:58).

## 5.7 DATA ANALYSIS

The data obtained was categorized and tabulated so as to easily determine the frequency of the various psycho-social characteristics, social problems and methods of intervention of the social worker. In general, the writer used nominal classification (Kogan, Leonard S. in Polansky, 1975:74) in order to identify the various psycho-social characteristics of the sample group and the various categories of roles and social work interventions used by the writer. In some cases (for example, the assessment of the sample group's level of education) ordinal scales were used.

The results and discussion of the data obtained will follow in the next chapter.

## 5.8 LIMITATIONS TO THE STUDY

Doing a retrospective study through use of archival data has limitations. The writer encountered the following limitations:

5.8.1 The existing data was not always precise or complete. This limitation is substantiated by Cozby, 1981:46

"Second we can never be completely sure of the accuracy of information collected by some one else".

5.8.2 In some cases there was discrepancies between the information in the social work files and Rehabilitation Clinic files. Although these discrepancies are to be expected because of the different disciplines with different aims involved, these discrepancies have an affect on the reliability and validity of the study findings.

5.8.3 The research demonstrated that the social work interviews were not comprehensive enough and therefore very superficial.

## 5.9 CONCLUSION

An attempt was made to present the methodology of the study.

Limitations, problems and mistakes have been mentioned so that the results which will be presented in the following chapter, can be evaluated in the light of the study limitations.



## CHAPTER SIX

### FINDINGS

#### 6.1 INTRODUCTION

The writer will describe and discuss the findings of the research study in this section with special reference to the influence of the patients' psycho-social characteristics on the role and task of the social worker. The interventions used by the writer in the sample group will highlight the interventions used in this particular vocational rehabilitation setting.

Most of the results will be presented in tabular form and will be discussed in terms of their relation to vocational rehabilitation and the role and task of the social worker. The findings will be discussed in two sections:

- o The psycho-social characteristics of patients referred for social work service
- o Social work services rendered at the Rehabilitation Clinic

#### 6.2 THE PSYCHO-SOCIAL CHARACTERISTICS OF PATIENTS REFERRED FOR SOCIAL WORK SERVICES

As the writer is employed in a medical rehabilitation setting it is

important to know the nature and extent of the patient's medical problems, the nature of the referral source and reason for the referral to the Rehabilitation Clinic. This information would indicate the extent and implications of the patient's disability as well as the reasons for the referral to the Rehabilitation Clinic. Being involved in a medical rehabilitation setting, it is important that the social worker should have a broad, general knowledge of the variety of existing physical (and where necessary, mental) disabilities. The social worker should also be aware of the medical, psychological and social implications of the various physical disabilities. Travis (1976: v) says

"To know the practical problems facing family and child (disabled person), the emotional burdens, and the effect on family relationships, the worker needs a framework of medical information."

TABLE 6.1: NATURE OF MEDICAL PROBLEMS IN THE SAMPLE GROUP

MEDICAL PROBLEMS IN PATIENTS REFERRED	NO. OF CASES
Psychiatric .....	4
Orthopaedic: traumatic .....	9
congenital .....	4
Respiratory .....	8
Amputations .....	5
Neurological: mental retardation .....	2
epilepsy .....	1
brain injury .....	5
hemiplegia/paraplegia .....	3
Other .....	3
No problem .....	1

From Table 6.1 it is evident that the major problems fall into three categories:

1. Orthopaedic problems : 13
2. Neurological problems : 11
3. Respiratory problems : 8

TABLE 6.2: DEGREE OF DISABILITY IN THE SAMPLE GROUP

SEVERITY OF DISABILITIES	NO OF CASES
Mild	25
Moderate	16
Severe	4

Table 6.1 reveals that the three most frequent medical problems of referred patients were of an orthopaedic, neurological and respiratory nature. This implies, as earlier mentioned in this chapter, that the social worker should be aware of both the medical and psycho-social implications of these specific disabilities so as to help the disabled person and his family in planning for a meaningful future. Knowledge and understanding of the medical implications of a disability such as a stroke (which is a neurological illness) can help the social worker to render a more effective service in educating patients and families to cope with difficult and strange situations such as the management of incontinence, partial paralysis, problems with transportation for wheelchair-bound persons as well as accessible housing. With regard to respiratory problems the social worker should be aware that certain allergies could cause respiratory problems and that this has an effect on obtaining and retaining employment. For example persons

allergic to certain chemicals may find difficulty in obtaining labourer work. When working with orthopaedic disabled persons the social worker should be knowledgeable with regard to the various orthopaedic appliances and the effect that that has on obtaining employment. For example for wheelchair-bound persons it is imperative that employment facilities should be accessible by either a ramp or a lift. Thus in relation to vocational rehabilitation the social worker needs to know the medical implications so as to determine whether a person is eligible for vocational rehabilitation, employment and the nature of employment that they could undertake.

Furthermore Table 6.1 also illustrate the need for a team approach to assess referred patients' vocational rehabilitation potential on a holistic basis, as discussed in the previous chapter three.

Table 6.1 reveals a major problem namely that the numbers of patients with other medical problems (such as dermatological problems or cerebral palsy) who may have potential for vocational evaluation but who are at present not referred, are unknown. This situation raises the question whether the Rehabilitation Clinic is utilized to its fullest extent.

Table 6.2 indicates that 25 patients in the sample group were mildly disabled. The fact that the more severely disabled persons were not referred could in part be due to the fact that patients are mainly referred to whether the nature of their disabilities or illnesses are disabling enough to preclude (or exclude) them from work and in this event render them eligible to apply for disability grants. It would

be interesting to determine how staff at Tygerberg Hospital perceive the function of the Rehabilitation Clinic and if educated about the nature of its services, whether they would not refer more suitable and some of the more severely disabled patients who with some input from the occupational therapist and physiotherapist could also be vocationally rehabilitated to participate in protective employment or home crafts. Another factor is that Tygerberg Hospital as a hospital primarily for the acutely ill is concerned with curative care and therefore overlooks rehabilitative care. Such an approach is not uncommon and is described by Rusk (1964: 20) in his statement

"... few hospitals offer patients comprehensive rehabilitation service. Hospital administrators complain that chronically ill (and disabled) patients are responsible for overcrowding, but few hospitals provide the third phase of medical care ..."

This attitude is unfortunate as it closes the opportunity for a holistic programme, including vocational rehabilitation such as discussed in chapters one and two.

TABLE 6.3: REASONS FOR REFERRALS TO THE REHABILITATION CLINIC

REASONS FOR REFERRAL	NO. OF CASES
Work assessment	17
Assessment for disability grants	23
Obtaining of orthopaedic appliances	2
Physical rehabilitation	1
Emotional support	1
Inappropriate referral (that is no referral reason)	1

Twenty three (51%) of the referrals were for the assessment of disability grants, which is in fact not the original aim of the Rehabilitation Clinic. This shift in task is due to the fact that from the beginning of 1987 the Administration: House of Representatives and hospital administrators expressed concern about the large amount spent on disability grants. It was then internally decided that in all doubtful cases patients of Tygerberg Hospital would then be referred to the Rehabilitation Clinic for a full work evaluation programme so as to decide whether a person is eligible for a disability grant or not. Bearing the above in mind, it is obvious that most disabled or chronically ill people are referred to the Rehabilitation Clinic not for vocational rehabilitation per se, but for financial reasons. This situation underlines Rusk's (1964: 20) statement which has been previously mentioned. In the allocation of disability grants, only medical reasons are accepted. This criterium restricts the role of the social worker mainly to that of assessing the patient's ability to manage his/her grant himself/herself or whether the administration of a government grant should be recommended. Furthermore the social worker also has a role in assessing the patients's social circumstances so as to ascertain whether there is no other alternatives of obtaining an income for the disabled person.

TABLE 6.4: NATURE OF REFERRAL SOURCES

REFERRAL SOURCE	NO. OF CASES
<u>Tygerberg Hospital</u>	
Department of Orthopaedics	14
Internal Medicine	13
Surgery	1
Psychiatry	1
Occupational Therapy	2
Social Work	3
<u>Government Departments</u>	
Administration: House of Representatives	3
Department of Manpower	1
Day Hospital Organisation	2
Department of Prisons	1
<u>Private Sector</u>	
Private Medical Practitioners	2
Clothing factory	1
<u>Other</u>	
Patient self	1

Table 6.4 reveals that the main referral source is Tygerberg Hospital (34 referrals). This is because the Rehabilitation Clinic falls under the jurisdiction of the Department of Community Health, Faculty of Medicine, University of Stellenbosch for which Tygerberg Hospital is the training hospital.

It is noticeable that the departments of Internal Medicine and Orthopaedics utilize the Rehabilitation Clinic more than others. This may indicate that they are more aware of the services offered by the Clinic as being of potential benefit to their patients. It may also indicate that patients who are mildly disabled due to disease and in financial need due to poor social-economic circumstances are more likely to be referred because of their need for financial assistance in the form of disability grants. As the state eligibility criteria for disability grants have become more stringent, the Rehabilitation Clinic has an additional task to assess whether in fact the mildly disabled would be capable of any form of work or not.

TABLE 6.5: IDENTIFYING DATA OF THE SAMPLE GROUP

DEMOGRAPHIC FACTORS		NO. OF CASES
<u>Race</u>	: White	6
	: Coloured	33
	: Black	6
<u>Sex</u>	: Male	31
	: Female	14
<u>Age</u>	: 15 - 30 years	12
	: 31 - 50 years	24
	: 50 - 70 years	9
<u>Language</u>	: Afrikaans	40
	: English	3
	: Xhosa	2



<u>Marital Status</u> : Single	18
: Divorced	5
: Separated	3
: Cohabiting	5
: Widowed	3

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From the above table it is evident that the majority of patients were Coloured Males which could be due to the fact that these people could become disabled because of the nature of their work (manual labour) and their personal habits such as smoking and abuse of liquor which will be discussed later in this chapter. Traumatic orthopaedic problems could be caused by accidents at work, whilst neurological problems and respiratory problems have a relationship with smoking of cigarettes and liquor abuse. The fact that the majority of patients were males could be related to the fact that males are breadwinners and in experiencing financial problems would seek financial aid. This tendency is understandable because if a father (breadwinner) in a family is unemployed and disabled, the family will experience insecurity because unemployment and lack of income has a direct influence on a family's housing, relationships, quality of life and roles in the family as discussed in chapter two. However, the fact that more males were referred to the Rehabilitation Clinic holds a discriminatory element. The impression is left that women is viewed as supported by their husbands and therefore not eligible for disability grants. This viewpoint however does not bear in mind the financial expenses that a physical disability has. The fact that the majority of patients were Coloured would be related to the

socio-economic-political situation which leaves Coloured people as a deprived, impoverished group of people. This implies that Coloured people are not only subjected to manual labour, but are also exposed to social circumstances characterized by crime and poverty. These circumstances could lead to physical disabilities. For example in an impoverished society with a high crime rate, criminal assaults could cause physical disabilities such as head injuries or orthopaedic problems, whilst respiratory problems could be caused not only by smoking but also overcrowded, damp, inadequate housing.

The majority of patients (80%) are in their labour productive years. This, together with the fact that the majority of patients are mildly disabled (table 6.2), implies that most of the patients could be able to perform some kind of work either in the open labour market, sheltered employment or protective employment. The previous mentioned demographic information clearly reveals the need for a sound vocational evaluation so as to determine whether a person is eligible for further vocational training and placement in the various employment options mentioned in the preceding chapter two. The social worker of the Rehabilitation Clinic not only has a task of assessing referred patients' rehabilitation potential, but should also educate referred patients with regard to the various employment facilities and the worth of permanent employment in comparison to obtaining a disability grant. Patients should be aware of that permanent employment have more financial and social benefits than a disability grant. In other words, patients should be helped to understand that in receiving a higher salary than a disability grant, it could help to improve their standard of living as well as quality of housing.

TABLE 6.6: RESIDENTIAL LOCALITY

RESIDENTIAL LOCALITY	NO. OF CASES
Urban	37
Rural	8

The majority (82%) of the patients live in urban areas. Bearing in mind the information on vocational aspects in chapter two, this stresses the need for further pre-vocational training and vocational training as well as the various employment opportunities mentioned in chapter two. The above need is also valid for the rural areas because of the general lack of work opportunities reported by patients from rural areas. (Table 6.7 reveals that the majority of patients were unemployed at the time of their referral). From the above information it is evident that the Rehabilitation Clinic has a role to play in advocating (together with The Association for the Physically Disabled) for vocational rehabilitation and employment facilities in both urban and rural areas in order to help disabled persons in their struggle against poverty and hardships.

TABLE 6.7: SOCIO-ECONOMIC FACTORS OF THE SAMPLE GROUP AT THE TIME OF REFERRAL

SOCIO-ECONOMIC FACTORS	NO. OF CASES
<u>Income</u>	
No income	28
Old age pension	1
Disability/Maintenance grant	8
Private income	9
Dependent on family, friends, church	33
<u>Occupational status</u>	
Employed	4
Unemployed	41
<u>Occupations of the sample group prior to disability</u>	
No information	2
Housewife	2
Drivers of vehicles	4
Labourer work	21
Char/cleaner/factory worker	8
Pensioners	3
Other	5
<u>Duration of unemployment at the time of referral</u>	
Period unemployment unknown	8
Less than 1 year	9
1 - 3 years	16
4 - 9 years	8
More than 10 years	4

The referral of 23 patients for assessment for eligibility for disability grants can be understood in terms of the fact that 41 of the patients were unemployed and 28 patients had no income at the time of their referral to the Rehabilitation Clinic. Exposed to poverty disabled persons can become so apathetic and dependent (Travis, 1976:6) that they view a government grant as the solution to all day-to-day living problems, that they are less interested in vocational rehabilitation and possible financial independence. In the management of such a succumbing life-style, the rehabilitation team and especially the medical social worker, has an important role in motivating disabled persons to participate in vocational evaluation with a view of secure employment which could increase a positive self-esteem and self-image as discussed in the preceding chapter two.

Twenty-nine (64%) of the patients in the sample group were prior to their referral involved in manual unskilled/semi-skilled work. This fact implies that disabled persons referred to the Rehabilitation Clinic are restricted to be re-employed in manual employment. Therefore the Rehabilitation Clinic has a responsibility to liaise with suitable employers in the open labour market as well as in sheltered and protective employment situation with a view of job placement. In this respect the current lack of sheltered and protective workshops as well as vocational training facilities is a restriction for successful placement.

Twenty-eight (62%) patients in the sample group revealed an unstable work record with frequent job changing which could be an additional handicap to successful job placement.

At the time of referral 16 patients were unemployed for a period between one to three years. The duration of unemployment not only influences a patient's motivation for vocational rehabilitation, but also his/her work habits and work personality. (Hershenson, 1981:95). Therefore one could conclude that the shorter the duration of unemployment, the higher the motivation and the less loss in work habits for the disabled person.

TABLE 6.8: EDUCATION STATUS AND PSYCHOLOGICAL FACTORS

EDUCATIONAL STATUS OF PATIENTS	NO. OF CASES
No schooling/illiterate	3
Junior primary school (that is: Sub A - St 1)	11
Senior primary school (that is: St 2 - St 4)	12
Junior secondary school (that is: St 5 - St 7)	12
Senior secondary school (that is: St 8 - St 10)	6
No information	1

With 51% (23) of the patients not having reached standard five, it is obvious that the Rehabilitation Clinic deals with patients who have a lack of education and who in many cases have to be trained as semi-skilled manual labourers. The lack of higher education can also imply that many patients may have limited social skills. Therefore

the medical social worker through group therapy (Bass in Moses and Patterson, 1971:182f) can enhance the development of patients' social skills during vocational rehabilitation with the view of successful job placement.

Regarding the psychological factors the research demonstrated that the interviews with the patients in the sample group were not comprehensive and inadequate information was obtained. Therefore only a few observations can be mentioned. Only six patients were referred to the Clinical Psychologist for an IQ test (using the Raven test). These patients presented as mentally retarded. A further 18 patients on one interview appeared to be of borderline mental retardation. The above inadequate information is unfortunate because a patient's IQ could indicate whether a disabled person could benefit for vocational rehabilitation and for which category of employment (that is: open labour market, sheltered employment or protective employment) would the disabled person be eligible.

#### HOUSING CIRCUMSTANCES

Unfortunately information on housing circumstances were not explored adequately and the data obtained is limited. However, the information obtained indicated certain housing problems and inadequacies. In eight known cases the toilet was outside the house. Only 14 patients had electricity, nine patients had warm water and 11 patients had a tap inside the house. Eight patients lived in homes that were overcrowded. There was no information about housing in 19 of the 45 patients in the sample group. However, the

preceding information could indicate that a number of patients live under primitive circumstances. The latter, however, were not because of the patients' physical disabilities but rather a result of a negative socio-economic-political situation. For example in South Africa the existence of apartheid is an added restriction to Black and Coloured disabled persons. With inadequate, overcrowded housing conditions as describe above, in townships situated far from public transport and employment facilities, it is understandable that many disabled persons do not have the motivation and psychological energy for vocational rehabilitation. Furthermore the high rate of unemployment and lack of employment opportunities in the general population disadvantage the disabled who have the able-bodied to compete with.



TABLE 6.9: RELIGIOUS AND SOCIAL AFFILIATIONS OF THE SAMPLE GROUP

RELIGIOUS INVOLVEMENT	NO. OF CASES
No information	5
Religious	21
Non-religious	19
Regular churchgoer	15
Actively involved	2
Religious, but not involved	5
HOBBIES/LEISURE ACTIVITIES	
No hobbies	6
No information	6
Active hobbies (that is: gardening, pets, sport, clubs, part-time work)	5
Passive hobbies (that is: reading, listening to the radio, watching TV, doing nothing)	28
Both active and passive hobbies	5
DAILY ROUTINE OF PATIENTS	
No information	5
Active routine (that is: busy with household activities, part-time, private jobs)	19
Not involved in any activities	21

The above table reveals that 24 patients had no/or few religious beliefs that could aid them in coping with their physical disabilities. Furthermore, the lack of active religious involvement

implies a lack of a positive support system which could be a motivating factor for both vocational rehabilitation as well as a resource for moral support to combat feelings of despondency as well as temporary financial aid.

Twenty-eight patients (62%) were involved in passive hobbies or leisure activities. This could be due to physical limitations (for example if one is unable to walk, it cannot be expected of such a person to be involved in general sport activities) but on the other hand lack of leisure activities could also be because to the patient's physical surroundings. For example patients may live in circumstances where it is impossible to have a garden or pets. Furthermore, since the majority of patients are impoverished it could well be that there is no financial means to have pets, a garden or to buy materials for handcrafts.

The above-mentioned factors can create a succumbing life style which in itself can lead to feelings of apathy and lack of interest in/or motivation for vocational rehabilitation. In essence, a negative self-esteem is not only because of a physical disability but can be exacerbated by impoverished surroundings. In such a situation religious involvement and a positive, active life style can enhance a disabled person's interest in life which again is needed for a positive self-esteem and the development of a work personality as previously discussed. The medical social worker can play an important role in enhancing a disabled person's interest in life, not only through individual - and group therapy but also in referring patients to community resources such as the sport clubs and

recreational clubs of the Association for the Physically Disabled, services centres such as the Elsie Rivier Service Centre of the Seventhday Adventist Church as well as support groups such as Headway (that is a support group for brain injured people and their families).

TABLE 6.10: SUBSTANCE ABUSE

SUBSTANCE ABUSE	NO. OF CASES
No information	1
Abstain	20
Abuse of liquor only	18
Abuse of cannabis only	1
Abuse of both liquor and cannabis	5

Twenty-four (53%) of the patients admitted to abusing liquor, cannabis or both mostly over weekends. The majority of patients admitted to have experienced physical symptoms of alcohol abuse such as intoxication, fits, black-outs, vomiting and loss of short-term memory. Eight patients reported social symptoms as a result of alcohol abuse. These included a criminal record due to intoxication, loss of housing and interpersonal and marital problems. Although the patients denied substance dependence (for example alcoholism) it is evident from the records that the patients habitually abused liquor.

Such abuse creates problems for successful vocational rehabilitation and job placement, because employers (who already may have reservations about employing disabled persons per se) are generally reluctant to employ persons with a drinking or cannabis problem. Besides the negative effect of substance abuse on vocational rehabilitation, it should be kept in mind that substance abuse does affect a person's health detrimentally which in effect can prevent successful vocational rehabilitation.

TABLE 6.11: ANTISOCIAL/CRIMINAL INVOLVEMENT

CRIMINAL RECORD	NO OF CASES
No information	6
Denial of criminal record	20
Involvement in criminal activities	13

Thirteen (29%) of the patients had a criminal record. Crimes committed were: theft, assault, intoxication, murder and homicide.

Although the minority of patients were involved in criminal activities, it is of note that a criminal record can create problems for job placement. For example: in an economic situation with a high rate of unemployment, employers are in the position to choose the best employees. A disabled person with a criminal record therefore has an additional handicap. Depending on the nature of the crime, a physically disabled person may have to come to terms not only with

his/her physical disability and unemployment, but may also have to recognize and work through the negative effect that a criminal record can have on one's life and future employment.

TABLE 6.12: RESULTS OF VOCATIONAL EVALUATION

RECOMMENDATION	NO OF CASES
Disability grant	19
Protective workshop employment	3
Sheltered employment	2
Open labour market	18

40% of the sample group were found fit for the open labour market which in part stresses the fact that many of the referred patients to the Rehabilitation Clinic are mildly disabled (Table 6.2) and therefore able to work. On the other hand 42% of the sample group were found eligible for a disability grant. This finding is due to various factors namely

- o an inability to work
- o age (that is: although not yet eligible for an old age pension, many patients were too old to find work easily, especially in the current economic climate with its high rate of inadequate employment facilities).
- o a lack of sufficient protective workshops and sheltered employment factories as mentioned in the preceding chapter two.

### 6.3 SOCIAL WORK SERVICES RENDERED AT THE REHABILITATION CLINIC

#### PSYCHO-SOCIAL ASSESSMENT

66% of the patients in the sample group were assessed according to an adapted Maudsley History Schedule (Departments of Psychiatry and Child Psychiatry at the Institute for Psychiatry and the Maudsley Hospital, London, 1987:1-22). In the case of 15 (34%) patients the writer focussed on single, specific aspects such as:

- (i) Employment.
- (ii) Finance.
- (iii) Housing.
- (iv) Interpersonal relationships.
- (v) Daily routine.
- (vi) Use of liquor/cannabis.
- (vii) Identifying data.
- (viii) Current social circumstances.
- (ix) Emotional problems.
- (x) Explanation of the occupational therapy programme of work assessments.
- (xi) Practical problems, namely, that of transport problems and lack of food.

The above-mentioned task of assessment is common practice in both generic and medical social work. This task is also necessary for the medical social worker to fulfil her role as member in the

rehabilitation team. The task of assessment is endorsed by Butrym and Horder (1983:8). They state:

"... we believe that the following aims of social work would be generally accepted ...  
To help people who experience a variety of problems in their social functioning, who are unhappy in various ways and to various degrees or who antagonize others by their behaviour and their failure to fulfil their social roles. This involves an informed assessment of their problems (and their psycho-social circumstances) ....."

Although 15 patients requested attention on specific aspects such as financial problems, these aspects not only highlighted the patients' major problems (lack of finance, unemployment, inadequate housing) but also gave insight into the social circumstances of referred patients.

Knowledge about the social circumstances of referred patients were used to motivate patients for vocational evaluation. In this respect the social worker found it necessary to explain the occupational therapy programme of vocational evaluation.

TABLE 6.13: FREQUENCY OF SOCIAL WORK INTERVIEWS/CONTACTS WITH VARIOUS RESOURCES

RESOURCES INTERVIEWED/CONTACTED	NO OF CASES
Individual interviews with patients only	36
Individual interviews with relatives only (relatives include spouse, parents, children)	8
Conjoint interviews with both patient and relatives	9
Interviews with others (that is: friends)	2
Written/telephonic contacts with government departments	17
Written/telephonic contacts with institutions (that is: churches, hospitals)	8
Written/telephonic contacts with community resources (that is: private welfare agencies, employers, support groups, service organisations and members of the community)	11

The above table reveals that 36 (82%) of the interviews were with patients only. Bearing in mind that people exist within a network of social systems (Pincus and Minahan, 1973:3) it would be appropriate to involve the various social systems of a disabled person such as the family, the school, the church and previous employers in the original assessment of the disabled person so as to obtain an objective holistic picture of the person concerned.



Since disabled persons are subjected to stigmatization as discussed in Chapter One, the support of the family network, can motivate a person for vocational rehabilitation. Conjoint interviews with both the disabled patient and his/her family furthermore create the opportunity to attend to both practical and emotional problems that may be experienced.

By involving the former employer of a disabled person, the rehabilitation team has the opportunity to obtain possible adjusted employment for the person concerned.

The fact that the social work services were mainly limited to one interview of one to two hours per person reveals that assessments were performed on a superficial level and that little or no time was available for rehabilitation counselling focussing on personal adjustment, personal and family problems and the handling of self-care and employment as discussed in the preceding Chapter Three.

Since little time seems available for the above-mentioned direct counselling services, the social worker is restricted to the referral of patients to various community resources such as private welfare organisations for professional help with problems such as alcoholism or interpersonal problems. From the above the impression is gained that the social worker of the Rehabilitation Clinic acts as a resource manager/co-ordinator which has been mentioned and discussed in the preceding Chapter Three, Table 3.1.

TABLE 6.14: PROBLEMS OF PATIENTS IDENTIFIED

TYPE OF PROBLEM	NO OF CASES
Emotional problems (anxiety, depression)	16
Finance	34
Unemployment	34
Housing	20
Lack of food	17
Lack of clothing	16
Interpersonal relationship problems	12
Abuse of liquor	10
Abuse of cannabis	4
Other	2

From the above it is evident that 77% of the patients were unemployed and had financial problems. This is understandable in the light of the fact that 23 of the referrals were for the assessment of the eligibility of patients for disability grants. Furthermore 41 the patients were unemployed and 28 had no income as revealed in Table 6.7 of this chapter.

Table 6.14 clearly reveals the problem of poverty (lack of food, clothing and adequate housing). Although the poverty of the patients is rather due to the societal situation than to the patients' physical disabilities per se, their physical disabilities could have exacerbated their poverty. In the above situation the social worker

has a definite responsibility to attend to practical bread-and-butter issues.

Although only 16 patients reported emotional problems (such as anxiety, tension, depression and feelings of inferiority), this does not imply that the other patients had no emotional problems. It could be that in the struggle against poverty, patients are so preoccupied with the practical problems of survival, that emotional feelings are repressed. The habitual abuse of liquor and cannabis as discussed earlier in this chapter can be viewed as a manifestation of coping with emotional problems such as depression, anxiety even anger towards the restrictions of poverty and not because of a physical disability. The latter, however, can contribute to emotional stresses stemming from encumbrant poor socio-economic circumstances.

TABLE 6.15: TASKS PERFORMED BY THE SOCIAL WORKER

TASKS	NO OF CASES
Psycho-social assessment	32
Individual therapy	29
Group therapy	1
Family therapy	1
Obtaining of collateral information	11
Referrals to community resources	25
Practical help	1

Table 6.16 reveals that the main social work tasks (73%) was that of psycho-social assessment. Individual therapy was limited to one session and usually interwoven with the assessment interview. Therefore one can hardly regard this task as being therapy. This "so-called therapy" consisted mainly of supporting and motivating patients towards a positive coping life style (Chapter Two), educating patients with regard to existing employment facilities and community resources as well as motivating patients to participate in the rehabilitation programme.

It is unfortunate that only in 25% of the patients was collateral information obtained. Collateral information should be regarded as important because patients can give incorrect information or come across in such a way which do not reveal a realistic picture of themselves.

Twenty five (57%) patients were referred to various resources for professional and practical help. For example seventeen patients were referred to government departments for food parcels, applications for disability grants and applications for admission to the sheltered employment factory. Six patients were referred to private welfare agencies for follow-up services and vocational training. Eight patients were referred to institutions for medical treatment and care whilst five patients were referred to community resources for financial aid and emotional support. The above-mentioned information reveals that the Rehabilitation Clinic is limited in its services and therefore patients have to be referred to other resources for

vocational pre-training and training courses, food parcels, clothing and professional social work services in the case of alcoholism and interpersonal and family relationship problems.

TABLE 6.16: ROLES OF THE MEDICAL SOCIAL WORKER

ROLES	NO OF CASES
Broker	22
Rehabilitation counsellor	42
Co-ordinator/Resource manager	30
Team member	41
Enabler	6
Teacher	29
Mediator	1
Advocate	7

The main roles of medical social worker were:

1. Rehabilitation counsellor (42 patients) with the main tasks of assessment, emotional support and motivation to participate in the rehabilitation programme. Unfortunately the role of enabler (Compton and Galaway, 1979:339-343) or rehabilitation counsellor (Angell in Moses and Patterson, 1971:68) is restricted to the assessment interview, the latter interview being utilized as a method to decide whether the disabled person is eligible for vocational evaluation.

In comparison to the views of Patterson (in Rubin and Roessler, 1978) and Angell (in Moses and Patterson, 1971) the role of the rehabilitation counsellor at the Rehabilitation Clinic is performed on a superficial level. Therefore it can be concluded that little or none counselling or therapeutic work is done by the medical social worker.

2. Team member (41 patients) with the tasks of dissemination of information about the disabled person's psycho-social circumstances to other team members as well as future planning for the person under consideration. Travis (1976:105) regard the task of team member as

"a capacity to co-ordinate social work concerns and operations with those of colleagues in other disciplines who provide services to the same clients ...."

3. Co-ordinator/Resource manager (30 patients) with the tasks of referrals and arrangement of services from other social workers and community resources such as support groups and government departments.
4. Teacher (29 patients) with the tasks of explaining the role of the medical social worker, the aim of the vocational evaluation programme and the importance of compliance with the rehabilitation team.

The above information indicates that the medical social worker at the Rehabilitation Clinic with her knowledge of physical disabilities, social systems, community resources and psycho-social implications of

physical disabilities, is an important team member with the various tasks of co-ordination of services, referrals and future planning. It seems that the most important roles performed by the medical social worker are those of team member and co-ordinator/resource manager (as discussed in the preceding Chapter Three). These roles concur with those mentioned by Compton and Galaway (1979:339-343) namely broker, teacher and advocate.

In comparison to the generic social worker, the medical social worker in a hospital based rehabilitation setting such as the Rehabilitation Clinic, has an important role to communicate on behalf of patients to hospital staff, as well as helping patients adjust to physical restrictions due to a physical disability and supporting patients with crises such as the possibility of loss of housing, lack of food, lack of finance and unemployment. It furthermore seems that the medical social worker in a vocational rehabilitation setting must be prepared to deal with the above-mentioned crises situations. These situations request, according to Butrym and Horder (1983:204)

"... ready accessibility and concentrated help over a relatively short span of time ...."

Although the majority of patients have been interviewed only once, it is obvious from Tables 6.14 and 6.16 that the medical social worker was highly involved with referrals to and contacts with various resources outside the Rehabilitation Clinic which implies that tasks rendered to disabled persons were mostly an indirect service.

(Angell et al in Moses and Patterson, 1971:66).

#### 6.4 SUMMARY OF FINDINGS

##### 6.4.1. Psycho-social characteristics of patients in the sample group

- (i) The main medical problems of the referred patients were orthopaedic, neurological and respiratory problems which restricted patients from obtaining secure employment and having a secure source of income.
- (ii) 55% of the patients were mildly disabled and with some input from physiotherapy and occupational therapy able to work either in the open labour market, sheltered employment or protective employment.
- (iii) Tygerberg Hospital is the main referral source. This is due to the fact that the Rehabilitation Clinic is linked to the Department of Community Health, Faculty of Medicine of the University of Stellenbosch and that Tygerberg Hospital is the training hospital for the medical students of the University of Stellenbosch. Therefore the Rehabilitation Clinic can be regarded as the immediate resource for the rehabilitation of disabled persons seen at Tygerberg Hospital.
- (iv) 50% (23) of the patients were originally referred for assessment of a disability grant. 19 of these patients (Table 6.12) were found eligible for a disability grant. The fact that nearly 50% of the sample group were found eligible for a disability grant is due to various factors such as



- o an inability to work.
- o age (some patients, although not yet eligible for an old age pension, were too old to obtain work easily. It has been experienced that in the current economic climate with its high rate of unemployment, persons older than 45 years, had difficulty in obtaining employment.
- o a lack of employment facilities in the open labour market as well as in sheltered employment and protective employment.

(vi) The predominant features of referred patients were

- o Coloured male persons.
- o Between 31-50 years old.
- o With no hobbies or religious involvement and a daily routine without any involvement in activities such as household chores or private part time jobs.
- o Low educational qualifications.
- o Previously employed as manual labourers.
- o History of job changing
- o Unemployed between one to three years at the time of referral to the Rehabilitation Clinic.
- o Had financial difficulties.
- o Residing with other persons with little privacy and under primitive conditions.
- o Habitually abuse of liquor and/or cannabis.

#### 6.4.2 Social work services rendered at the Rehabilitation Clinic

- (i) The main service was that of the psycho-social assessment of referred patients to ascertain the patients' potential and ability for vocational evaluation. Other services concentrated on the solving of problems such as lack of finance, unemployment inadequate housing, the abuse of liquor and/or cannabis and poverty.
- (ii) The majority of interviews/contacts were mainly with patients only and also mainly restricted to one interview per patient.
- (iii) The main roles fulfilled by the medical social worker were:
  - o rehabilitation counsellor on a limited basis.
  - o co-ordinator/resource manager (which could be viewed as roles of advocate and broker).
  - o team member.
  - o teacher.
- (iv) The social work interventions used to problem solve were:
  - o limited psycho-social assessments of patients.
  - o limited individual therapy restricted to motivation, education and emotional support.
  - o referrals of patients to community resources such as government departments and private welfare agencies to attend to problems of lack of finance, food, housing,

vocational training, unemployment, substance dependency and interpersonal relationship problems.

## 6.5 CONCLUSION

Having attempted to discuss the findings of the research study the following chapter will attend to

- o an evaluation of the findings.
- o recommendations with regard to the Rehabilitation Clinic and the post of medical social worker.
- o implications for further research.
- o an evaluation of the study.

## CHAPTER SEVEN

### CONCLUSIONS

#### 7.1 INTRODUCTION

The main goal of the Rehabilitation Clinic at Karl Bremer Hospital is that of vocational evaluation which is the first phase in vocational rehabilitation (Rubin and Roessler, 1978:123). Due to the concern of government officials about the high expenditure on disability grants, the Rehabilitation Clinic was requested to assess disabled applicants for disability grants so as to ensure that grants were allocated only to persons who are unfit for the open labour market or sheltered employment. This additional task allocated to the Rehabilitation Clinic implied that most disabled persons who requested a disability grant and whom medical officers doubted the necessity of a government grant were referred to the Rehabilitation Clinic for vocational evaluation so as to ascertain whether a disabled person was eligible for a grant or not.

The medical social worker plays a major role in the above-mentioned setting. The medical social worker is requested to assess the psycho-social circumstances of referred patients, give feedback to the rehabilitation team and co-ordinate referrals to the various

resources to the benefit of the patient.

In this chapter the writer will attempt to evaluate the implications of the psycho-social characteristics of referred patients for vocational rehabilitation as well as to evaluate the role and task of the medical social worker against the background of the theory discussed in Chapter Three.

## 7.2 THE PSYCHO-SOCIAL CHARACTERISTICS OF DISABLED PATIENTS REFERRED TO THE REHABILITATION CLINIC

In the previous chapter a summary of the psycho-social characteristics of a sample group of referred disabled persons to the Rehabilitation Clinic at Karl Bremer Hospital were given. These findings as mentioned in Chapter Six imply that the medical social worker attached to a multi-diagnostic clinic such as the Rehabilitation Clinic should be familiar with the medical, psychological and social consequences of the various physical disabilities so as to render an effective and realistic social work service.

The findings discussed in Chapter Six revealed that the patients' social circumstances were of such a nature that they were not referred for vocational evaluation per se, but for the assessment of eligibility for disability grants. It was also revealed that patients found fit for work in the open labour market, with no need for vocational training, were in fact not disabled by their medical conditions, but rather by their social circumstances. Since the

disabled patients of the Rehabilitation Clinic suffer circumstances characterized by poverty and financial difficulties, it is understandable that these patients view a disability grant as a solution to overcome their financial difficulties.

Against the background of poverty, discrimination and a deprived life style, the passive, succumbing life style of the majority of patients may reveal feelings of being overwhelmed. The general tendency of patients to abuse liquor and/or cannabis can also be regarded as an escape mechanism to cope with the reality of deprivation.

From the findings it became clear that socio-economic circumstances have a more discriminatory effect than the physical disability per se (Chapter Two). This phenomena has a major influence on a disabled person's self-image and self-esteem. Should a person be unemployed for a long period, one could expect such a person to lose confidence in his/her capabilities as a worker. Bearing the latter in mind, the writer agrees with Hershenson (1981:91f) that disabled persons engaged in vocational rehabilitation need to develop both work personality and work competence. The above implies that the patients of the Rehabilitation Clinic (with their specific characteristics which include low educational qualification, passive, succumbing life style, unemployment and abuse of liquor and cannabis) are in need of pre-vocational and vocational training (Grabe et al, 198:12).

### 7.3 THE ROLE AND TASK OF THE MEDICAL SOCIAL WORKER AT THE REHABILITATION CLINIC

The findings discussed in chapter six revealed that the role and task of the medical social worker is both influenced by the psycho-social characteristics of the patients and by the expectations of the Rehabilitation Clinic.

The role of Rehabilitation Counsellor (Moses and Patterson, 1971) is influenced by both the rehabilitation team and the psycho-social circumstances of referred patients. The medical social worker (the writer) had the task of assessing the eligibility and rehabilitation potential of referred patients. In assessing patients' psycho-social circumstances, problems of patients that require social work attention, are revealed. In comparison to Rubin and Roessler (1978:92) the writer does not render placement, follow-up and post-employment services. Furthermore, counselling services with regard to adjustment, personal problems and employment skills (that is social skills to obtain and retain employment; preceding Chapter Two) are not rendered. This situation is unfortunate because in the redevelopment of a disabled person's work personality, counselling can play an important role in improving self-esteem and self-confidence.

As described in Chapter Four and confirmed by the findings mentioned in Chapter Six, the medical social worker also had a role and task of Co-ordinator/Resource manager which was mainly the expectation of the rehabilitation setting and due to the fact that the

Rehabilitation Clinic renders a limited service. In the above-mentioned role the medical social worker had to refer patients to appropriate services. For example, many of the patients have a lack of food and clothing. As the Rehabilitation Clinic does not give material assistance, the medical social worker had to arrange for services from other resources such as private welfare organisations. Although the tasks of the co-ordinator/resource manager seems to be concerned with practicalities and administration, these tasks are not to be disregarded. It is well-documented by Travis (1976) and Hollis and Woods (1981:41) that practical problems such as poverty, inadequate housing and unemployment can cause psychological problems (for example: depression, demotivation, and a passive, succumbing life style). In attending to concrete problems as well, a psycho-social approach (Wright, 1983) is utilized at the Rehabilitation Clinic. Furthermore, inadequate co-ordination and incorrect referrals, can cause an inadequate service; the latter being time consuming but also a demotivating factor if patients are sent from one resource to another, not obtaining results.

The findings discussed in Chapter Six revealed that the medical social worker also had a role of teacher. The role of teacher is due to the fact that many of the patients viewed themselves as unable to work and therefore requested a disability grant. It has been experienced that the majority of the patients were ignorant of existing facilities and community resources. Therefore the writer in the role of teacher had the task to educate the disabled persons with regard to various existing facilities, their personal capabilities,



vocational rehabilitation and to motivate patients to utilize the various rehabilitation services.

Findings also revealed that the writer had a role of team member. This fact confirmed that the team approach (discussed in Chapter Three and confirmed by Watt, 1985:192) is viewed as a necessity and utilized at the Rehabilitation Clinic. In agreement with Moore (Moses and Patterson, 1971:309) the findings revealed that the medical social worker is an important person at the Rehabilitation Clinic, being the "generalist", familiar with community resources, co-ordinating services, referring to appropriate resources and ensuring the completion of each disabled person's rehabilitation programme.

With regard to rehabilitation counselling the following needs to be mentioned:

- (i) Although rehabilitation counselling at the Rehabilitation Clinic was restricted to the task of limited psycho-social assessment of patients, it has been experienced that the use of the adapted Maudsley History Schedule in comparison to the guideline for the intake interview proposed by Rubin and Roessler, 1978:131-133 (preceding Chapter Three) gives a far broader picture of each patient's psycho-social circumstances.
- (ii) Rehabilitation counselling, as described in Chapter Three, is not performed at the Rehabilitation Clinic. However, bearing in mind the psycho-social characteristics of the referred

patients, the following theoretical approaches proposed by Thomas and Butler (in Parker and Hansen, 1981 and Moses and Patterson, 1971) can be utilized when needed and found necessary:

- o Rational approaches, especially reality therapy
- o Group therapy

Since patients are interviewed in a limited time, rehabilitation counselling may have to be conducted after hours, or an extra post will be needed to render counselling services. The above-mentioned approaches can be used to render effective service to disabled persons who exist within a society of poverty and are struggling with practical, concrete problems. It has been experienced that if the practical problems of everyday living are managed effectively, disabled persons experience emotional relief of stress and tension related to poverty.

#### 7.4 RECOMMENDATIONS

##### 7.4.1 Introduction

In Chapter Two possible recommendations with regard to general societal problems such transport, housing, education and employment have been discussed. The following recommendations will focus on the Rehabilitation Clinic and the medical social worker of the above-mentioned Clinic.

#### 7.4.2 Recommendations: Rehabilitation Clinic

- (i) For successful vocational rehabilitation the Rehabilitation Clinic should include pre-training and training courses to ensure an adequate preparation of disabled persons for employment.
- (ii) To facilitate continuity and co-ordination of services the occupational therapist of the vocational evaluation area (presently situated at Tygerberg Hospital) ideally should be in the same locality as the Rehabilitation Clinic.
- (iii) More staff members should be allocated to the Clinic, because a need for more staff members (medical and para-medical) exists. At present all staff members are overloaded to the extent that no in-depth services can be rendered. For example: the occupational therapist is only able to attend to the evaluation phase of vocational rehabilitation, whilst the medical social worker is unable to render group therapy or individual therapy as discussed in Chapter Three.
- (iv) It is advised that a placement officer should be appointed to the Rehabilitation Clinic. The placement officer (who should be a qualified and experienced occupational therapist) should be responsible for obtaining appropriate vocational opportunities, referring vocationally rehabilitated disabled

families) so as to expand the support systems of disabled persons referred to the Rehabilitation Clinic. This involvement seems necessary because of the problem of discrimination (Chapters One and Two) and would not only ensure co-operation with the various community resources but also aid the medical social worker in referring patients to appropriate resources. Furthermore active involvement with community resources could enhance the social worker's identification and empathy with physically disabled persons. This in itself could create a greater sensitivity for the needs of physically disabled persons and as well create an opportunity for the social worker to advocate together with disabled persons and their families, for a discrimination free environment as discussed in Chapters One and Two.

#### 7.5 IMPLICATIONS FOR FURTHER RESEARCH

In the previous chapters, two major features were looked at:

- (i) The psycho-social characteristics of patients of the Rehabilitation Clinic referred to the medical social worker.
- (ii) The role and task of the medical social worker of the Rehabilitation Clinic.

At present the success of the rehabilitation programme of the Rehabilitation Clinic is unknown. For example: it is unknown

whether patients have been placed successfully in a vocational situation. The effect of social work intervention is also unknown.

It seems, therefore, appropriate that a follow-up study should be done on a sample group of patients with the following objectives:

- (i) An assessment of the disabled person's functioning of life, including quality of life.
- (ii) If a patient has been employed, the quality of functioning in the work situation needs to be assessed.
- (iii) An assessment of the possible improvement of disabled patients' social circumstances and emotional state of mind.
- (iv) An assessment of the patients' perception of social work intervention.

Should such a study be considered, follow-up visits, face-to-face interviews, a larger sample group and a pilot study be necessary so as to ensure a higher percentage of reliability and validity.

#### 7.6 EVALUATION OF THE STUDY

It was attempted to obtain a profile of the psycho-social characteristics of physically disabled persons referred to the Rehabilitation Clinic and to determine the effect of these characteristics on the role and task of the medical social worker of

the above-mentioned Clinic.

It was determined that the majority of disabled persons referred to the Rehabilitation Clinic were Coloured male persons, in their labour productive years, with poor educational qualifications and involved in manual labour. The majority of patients, however, were mildly to moderately disabled and able to perform vocational duties. Rendering social work services to a group of patients with the above-mentioned characteristics, imposed a concrete and practical stance on the medical social worker. The medical social worker therefore has a major role as educator and resource manager to educate and motivate patients for participation in the vocational rehabilitation programme and referral to appropriate community resources.

The outstanding conclusion of this study is the fact that the major roles and tasks of the medical social worker as rehabilitation counsellor, team member and co-ordinator were both influenced by the expectations of the team members of the Rehabilitation Clinic and the psycho-social characteristics of the disabled persons. The writer furthermore came to the conclusion that the psycho-social characteristics of disabled persons also influenced the techniques used and the behaviour and professional stance of the medical social worker.

This conclusion created a final awareness that the role and task of a medical social worker in a vocational rehabilitation setting is a

comprehensive one of being both rehabilitation counsellor and co-ordinator. Angell et al (Moses and Patterson, 1971:66-68) appropriately views the social work role as:

"a problem solving role"

with the task

"to perceive the multiple problems of each of his clients and plan interventions which is crucial".

## APPENDIX



ITEM 1

DIE FUNKSIONELE EVALUASIE VAN GESTREMDHEID

MAATSKAPLIKE EVALUASIE

Skaal:	DATUM .....
0 = Baie swak	PASIENT .....
1 = Gebrekkig	OUDERDOM .....
2 = Matig	HOSP. NO. ....
3 = Goed	

FAMILIEGESKIEDENIS	0	1	2	3
INTERPERSOONLIKE VERHOUDINGE	0	1	2	3
SOSIO-KULTUREEL	0	1	2	3
OPVOEDKUNDIGE PEIL	0	1	2	3
WERKSGESKIEDENIS	0	1	2	3
FINANSIES	0	1	2	3
BEHUISING	0	1	2	3
KRIMINELE REKORD	0	1	2	3
ALKOHOL/DAGGA	0	1	2	3
PSIGIESE FAKTORE	0	1	2	3

TOTAAL: ...../30

.....%

OPMERKING

.....

.....

.....

.....

.....

.....

.....

ITEM 2

TYGERBERG HOSPITAL : DEPARIMENT OF SOCIAL WORK  
 TYGERBERG-HOSPITAAL : DEPARTEMENT MAATSKAPLIKE WERK

NAAM .....	NOMMER .....
NAME	NUMBER
ADRES .....	TEL NR .....
ADDRESS	TEL NO
GEBORTE DATUM .....	RAS .....
DATE OF BIRTH	RACE
	GESLAG .....
	SEX
KERKVERBAND .....	HUWELIKSTAAT ....
DENOMINATION	MARITAL STATE
	HUISTAAL .....
	HOME LANGUAGE
BEROEP .....	INKOMSTE .....
OCCUPATION	INCOME
WERKGEWER .....	TEL NR .....
EMPLOYER	TEL NO

---

MEDIESE DIAGNOSE .....	AFDELING .....
MEDICAL DIAGNOSIS	DEPARTMENT
VERWYS DEUR .....	DATUM .....
REFERRED BY	DATE

---

VERANTWOORDELIKE FAMILIELID/PERSOON  
 RESPONSIBLE RELATIVE/PERSON

NAAM .....	VERWANTSAP .....
NAME	RELATIONSHIP
ADRES .....	TEL NR .....
ADDRESS	TEL NO
BEROEP .....	INKOMSTE .....
OCCUPATION	INCOME
WERKGEWER .....	TEL NR .....
EMPLOYER	TEL NO

---

GESINSAMESTELLING  
 FAMILY COMPOSITION

ANDER INLIGTING  
 OTHER INFORMATION

**ITEM 3**

WHAT  
ARE THE SIGNS  
OF ALCOHOLISM?

The following questions will help a person learn if he has some of the symptoms of alcoholism. He might use the questionnaire as a rough checklist to determine whether he or a member of his family may need help.

YES NO

☐ ☐

1. Do you occasionally drink heavily after a disappointment, a quarrel, or when the boss gives you a hard time?

☐ ☐

2. When you have trouble or feel under pressure, do you always drink more heavily than usual?

☐ ☐

3. Have you noticed that you are able to handle more liquor than you did when you were first drinking?

☐ ☐

4. Did you ever wake up on the "morning after" and discover that you could not remember part of the evening before, even though your friends tell you that you did not "pass out"?

☐ ☐

5. When drinking with other people, do you try to have a few extra drinks when others will not know it?

☐ ☐

6. Are there certain occasions when you feel uncomfortable if alcohol is not available?

☐ ☐

7. Have you recently noticed that when you begin drinking you are in more of a hurry to get the first drink than you used to be?

☐ ☐

8. Do you sometimes feel a little guilty about your drinking?

☐ ☐

9. Are you secretly irritated when your family or friends discuss your drinking?

☐ ☐

10. Have you recently noticed an increase in the frequency of your memory "blackouts"?

☐ ☐

11. Do you often find that you wish to continue drinking after your friends say they have had enough?

☐ ☐

12. Do you usually have a reason for the occasions when you drink heavily?

☐ ☐

13. When you are sober, do you often regret things you have done or said while drinking?

☐ ☐

14. Have you tried switching brands or following different plans for control-

YES NO

☐ ☐

15. Have you often failed to keep the promises you have made to yourself about controlling or cutting down on your drinking?

☐ ☐

16. Have you ever tried to control your drinking by making a change in jobs, or moving to a new location?

☐ ☐

17. Do you try to avoid family or close friends while you are drinking?

☐ ☐

18. Are you having an increasing number of financial and work problems?

☐ ☐

19. Do more people seem to be treating you unfairly without good reason?

☐ ☐

20. Do you eat very little or irregularly when you are drinking?

☐ ☐

21. Do you sometimes have the "shakes" in the morning and find that it helps to have a little drink?

☐ ☐

22. Have you recently noticed that you cannot drink as much as you once did?

YES NO

☐☐

23. Do you sometimes stay drunk for several days at a time?

☐☐

24. Do you sometimes feel very depressed and wonder whether life is worth living?

☐☐

25. Sometimes after periods of drinking, do you see or hear things that aren't there?

☐☐

26. Do you get terribly frightened after you have been drinking heavily?

If you answered "yes" to any of the questions, you may have some of the symptoms of alcoholism.

SANCA OFFICES

Cape Town ..... 24 5260/1/2  
Athlone ..... 637 1380/1  
Paarl ..... (02211) 29671  
25050  
Stellenbosch ..... (02231) 5747

WHAT ARE THE SIGNS OF ALCOHOLISM ?



SOUTH AFRICAN NATIONAL COUNCIL ON ALCOHOLISM AND DRUG DEPENDENCE (WESTERN CAPE SOCIETY) SM  
S. A. NATIONALE RAAO INSAKE ALKOHOLISME EN AFANKLIKHEID VAN VERDOOFINGSMIDDELS (VES-KAAPLAND VERENIGING)

THE PSYCHO-SOCIAL CHARACTERISTICS OF PATIENTS REFERRED TO THE SOCIAL  
WORKER AT THE REHABILITATION CLINIC, KARL BREMER HOSPITAL, BELLVILLE

.....

Occupation: .....

School Qualifications:      None      Sub-A - St 1      St 2 - St 5  
St 6 - St 7      St 8 - St 10      St 10 - +

Occupation: Permanent Casual

labourer: farm factory building trade

other: .....

Personality: quiet docile aggressive: verbal/physical

strictly religious strong personality no information

2.3 Biological mother: Alive Deceased

If deceased: at what age: .....

diagnosis: .....

Drinker: Yes No Abuse of Liquor: Yes No

Smoker: Cigarettes: Yes No Cannabis: Yes No

School Qualifications: None Sub A - St 1 St 2 - St 5  
St 6 - St 7 St 8 - St 10 St 10 - +

Occupation: permanent casual

domestic worker: char sleep-in

labourer: factory

housewife: .....

other: .....

Personality: quiet docile aggressive: verbal/physical

strictly religious strong personality no information

2.4 By whom was patient raised / Childrearing:

Own married parents Single parent: mother father

Co-habiting parents Grandparents: paternal maternal

Other .....

Did biological father support patient? Yes No

No information available .....

2.5 Siblings:

Number of siblings: ..... Brothers: .... Sisters .....

Patient's position in family .....

Did siblings have same biological father?      Yes      No  
 Did siblings have same biological mother?      Yes      No  
 Among siblings: Any criminal record?      Yes      No  
                                  Abuse of liquor/cannabis?      Yes      No  
 General school qualifications of siblings:      None      Sub A - St 1  
 St 1 - St 5      St 6 - St 7      St 8 - St 10      St 10 - +  
 Occupations of siblings:      Permanent      Casual  
     labourer:      factory      building trade      domestic work      farm  
     other .....  
 Marital status of siblings .....  
 Any illegitimate children .....  
 No information family available .....

3. Own family of patient:

Marital status: .....  
 If unmarried/cohabiting, any children?      Yes      No  
 If married, was marriage forced by wife's pregnancy?      Yes      No  
 If patient has illegitimate children, does patient support the children?      Yes      No  
 Number of children: .....  
 If patient is sexually active, are contraceptives used?      Yes      No

4. Interpersonal relationships:

Biological father:      Good      Fair      Bad  
 Biological mother:      Good      Fair      Bad  
 Significant others (e.g. people who raised patient, other than biological parents):      Good      Fair      Bad  
 Siblings:      Good      Fair      Bad  
 Spouse/co-habitant:      Good      Fair      Bad  
 Children:      Good      Fair      Bad  
 Schoolteachers:      Good      Fair      Bad



Friends:	Good	Fair	Bad
Superiors:	Good	Fair	Bad
Colleagues:	Good	Fair	Bad

5. Socio-Cultural Aspects:

Religious:      Yes      No

Involvement in church activities:    regular churchgoer

actively involved      non-practising

Hobbies:    active (e.g. gardening, playing of sport, pets) .....

.....

passive (e.g. reading, watching TV, listening to radio) .....

.....

Member of library, clubs:      Yes      No

Daily routine:

active (helps with household chores, gardening, part-time private jobs)    Yes      No

passive (sits around, walks around, drinks, smokes)    Yes      No

Reads the newspaper:    Yes      No

Listens to the Radio or TV news      Yes      No

No information

6. Education:

Standard passed .....

Ordinary class                      Adaption Class

Any standards failed?    Yes      No

Promoted to standards without passing?    Yes      No

Age when patient left school .....

Reason for leaving school .....

No information .....

7. Work history:

No work history .....

Permanent jobs: number .....

longest stay .....

shortest stay .....

Reasons for leaving job .....

.....

Casual jobs: number of jobs .....

Occupation : labourer factory worker building trade other

clerical work

If unemployed, the duration .....

Current employment situation .....

No information available .....

8. Finance:

Income: None Government Pension Old Age/Disability

Private income .....

Wages per week .....

Total income per month .....

Expenses: Use of hire purchase Yes No

Rent in arrears Yes No

Telephone Yes No

Electricity Yes No

Food debt Yes No

Clothing Yes No

9. Housing:

Institution	Community	If community:	flat
			house
			maisonette

Own home: Yes No Rent home: Yes No

Bedrooms: One Two Three more

If only toilet:      In the home      Outside the home

Electricity:      Yes      No

Warm water:      Yes      No

Tap:      Inside the home      Outside the home

Number of people in the home: .....

.....

.....

Overcrowding:      Yes      No

Does each member have his/her own bed:      Yes      No

Do members share beds:      Yes      No

Does patient have a bed:      Yes      No

Are beds available?      Yes      No

No information available .....

10. Criminal record:

Does patient have a criminal record?      Yes      No      Unknown

If "yes", what was the crime committed? .....

.....

Was crime committed during patient's intoxication: Yes      No      Unknown

Sentence:      Imprisonment:      Yes      No      Fine only:      Yes      No

Number of crimes and imprisonments: .....

.....

11. Use of liquor and/or cannabis:

Only liquor: .....

Only cannabis: .....

Liquor and cannabis: .....

Use:      Occasionally      Socially      Abuse

If abuse:      During week      Every day/evening

Amount used: .....

Symptoms of abuse:

medical: blackouts delirium tremens fits epileptic fits  
trembling vomiting and stomach problems lack of appetite  
liver cirrhosis peripheral neuropathy loss of short-term memory  
psychotic-episodes  
social: loss of jobs marital problems interpersonal problems  
criminal record

12. Psychological factors:

No information .....  
Limited information .....  
Appearance:.....  
Speech: .....  
Behaviour: .....  
Affect and mood: .....  
Flow (tempo) of thought: .....  
Form of thought: .....  
Possession of thought .....  
Content (delusions) of thought .....  
Perception: Illusions: Yes No Hallucinations: Yes No  
Cognitive funtions: IQ .....  
Orientation: .....  
Awareness: .....  
Memory: Short term ..... Intermediate .....  
Long term .....  
Abstract thinking: .....  
Insight: .....  
Judgement: .....  
Self-description by patient: .....  
.....

Defence mechanisms: narcissistic: denial projection

immature: acting-out behaviour passive-aggressive

regression somatisation

neurotic: displacement intellectualisation rationalization

reaction-formation repression

mature: altruism sublimation suppression

Phases of acceptance with regard to the losses the patient is

experiencing: denial anger bargaining depression

acceptance

Is the acceptance passive or active: .....

Did the patient comply with the rehabilitation programme? Yes No

ITEM 5SCHEDULE 2AN EVALUATION OF THE SOCIAL WORK SERVICES AT THE REHABILITATION CLINIC,KARL BREMER HOSPITAL, BELLVILLE

1. Was a psycho-social history taken?      Yes      No
2. If "no", on what aspect did the social worker concentrate?  
     finance    housing    emotions    interpersonal relationships  
     employment    use of liquor/cannabis    daily routine    identifying  
     data    Explanation of rehabilitation programme    other .....
3. Interviews/social work contacts with various resources:  
     Patient Only              Relatives Only              Friends Only  
     Patient plus relatives/friends      Welfare Agencies  
     Institutions      Government Departments  
     Community Resources (e.g. support groups, service organisations)  
     Other .....
4. Number of interviews and contacts with various resources:  
     Patient only .....Relatives Only ..... Friends Only .....  
     Conjoint interviews with patient and relatives/friends .....  
     Welfare agencies ..... Institutions .....  
     Government Departments ..... Community resources .....  
     Other .....
5. Psycho-social problems identified:  
     emotional problems    finance    unemployment    housing  
     lack of food    lack of clothing    interpersonal relationships  
     abuse of liquor/cannabis    Other .....
6. Tasks performed by the social worker:  
     Psycho-social assessment .....

Therapeutic task: Individual therapy (support/motivation).....

Group therapy .....

Family therapy .....

Obtaining of collateral information .....

Referrals to community resources for professional and practical help

Government Departments .....

Private welfare agencies .....

Institutions .....

Community resources (support groups, service organisations) .....

Practical help from the social worker: clothing transport fare

7. Role of Social Worker:

Resource manager/broker .....

Rehabilitation counsellor .....

Co-ordinator .....

Team member .....

Enabler .....

Teacher .....

Mediator .....

Advocate .....

8. Team approach:

Was the patient discussed during a team meeting: Yes No

If yes, how many times .....

Who is involved in the team: medical doctor social worker  
occupational therapist nursing sister physiotherapist  
clinical psychologist patient

Did the patient participate in his/her future planning: Yes No

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persons to appropriate employment facilities. After-care services should also be rendered by the placement officer so as to attend to possible vocational problems between employer and employee. An after-care service could prevent a drop out of disabled persons and ensure successful placement.

7.4.3 Recommendations: Medical Social Worker: Rehabilitation Clinic

- (i) It is recommended that a full time social worker should be allocated to the Rehabilitation Clinic in order to render individual counselling services and group therapy services.
- (ii) It is furthermore recommended that social auxiliary workers should also be appointed to the Rehabilitation Clinic so as to relieve the medical social worker from practical tasks such as the co-ordination of services, applications for disability grants and referrals for material assistance. The appointment of social auxiliary workers could allow the medical social worker to focus on the roles and tasks of teacher and rehabilitation counsellor as discussed in previous chapters.
- (iii) The writer furthermore recommends the involvement of the medical social worker with community resources (for example: The Association for the Physically Disabled, service centres, and support groups such as Headway which is a support group for persons with brain injuries and their